AIDS:

THE ARBITRATOR'S ROLE IN THE POST-PANIC PERIOD

Labor Arbitration Seminar
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A. INTRODUCTION

The purpose of this brief paper is to explore the impact of Acquired Immune Deficiency Syndrome (AIDS) on the arbitrator's resolution of workplace grievances. The principal question is whether arbitrators should develop new standards for use in AIDS related cases. The short answer is no. The traditional standards developed for analogous non-AIDS related disputes will serve the arbitrator equally well in an AIDS case. (The most basic advice is appropriate here: If it isn't broken, don't "fix" it.)

A study of the AIDS epidemic from a scientific perspective does not seem to turn up any unique workplace issues. AIDS is a blood borne fatal disease[1] which health authorities maintain is extremely difficult to contract in the normal employment setting.[2] In a workplace where employees or customers are not exposed to the blood or bodily fluids of infected workers, AIDS seems little different than ailments such as cancer, diabetes or

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[1] See the discussion in Part C below.

[2] For the purposes of this discussion, a "normal" work setting is one where employees and customers do come into contact with the bodily fluids of others. In work settings where such contact is common, (legalized prostitution, health care and emergency services,) the risk of contracting AIDS can be extremely high. See Appendix K for a list of articles discussing AIDS issues in the health care context.

heart disease. These conditions are also often fatal to the "infected" worker, can cause debilitation which raises safety concerns, but pose no direct threat of infection to others. Where exposure to bodily fluids is present in the workplace, AIDS seems little different than other infectious diseases which pose a threat to co-worker safety.

What seems to separate AIDS from all other medical conditions is its complex social and political baggage. The popular perceptions surrounding AIDS often overshadow the purely factual issues. As a consequence there are calls for an "AIDS approach" to medical research, a "new" approval process for experimental drugs, and "fundamental premises" unique to the arbitration of AIDS related employment disputes.[3] Proponents argue that the infectious nature of AIDS coupled with its fatal course make it a unique and unparalleled social problem. However, at least in the arbitration arena, the tools at hand are more than adequate to resolve AIDS related controversies.

An extensive examination of society's response to the AIDS epidemic is beyond the scope of this paper. However, in a case involving AIDS, the arbitrator can expect the parties to brief him or her on the "facts" surrounding the disease.[4] Given the

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[3] See the discussion in Footnote [100].

[4] Arbitrators are being increasingly called upon to make decisions where the parties' contractual obligations turn on medical evidence. The arbitrator's ignorance of medicine and the medical facts upon which a particular case may turn

complexity of the scientific evidence and the divergence of opposing views, an arbitrator who wants to make an intelligent, factual decision needs to have a basic understanding of the historical and scientific issues which can shape an AIDS related dispute.

Though this is ostensibly an paper on arbitration, the initial discussion is devoted to basic background material on AIDS. While this material could have been relegated to an appendix, an understanding of the basic facts[5] concerning AIDS is essential to the later discussion. As a consequence, it seemed more straight forward to include this material in the body of the paper than to excise it and then direct the reader to review Appendix A before beginning the paper itself. The discussion is divided into five sub-topics: the social history of AIDS; the medical facts most relevant to AIDS workplace issues; the arbitrator's role; the possible sources of external law and public policy; and, finally, common AIDS related workplace issues with suggested solutions under each arbitration model.

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can constitute a serious impediment to the decision making process. For a general discussion of this issue see: Zack & Zack, *Arbitrators and Medical Evidence,* 39 Arb.J. 6 (S. 1984) and Wilson, *Medical Evidence in Arbitration: Aspects and Dilemmas,* 39 Arb.J. 11 (S. 1984).

[5] As in many areas of endeavor, what passes for "facts" are those things agreed upon by a majority of scientists working in the field. While a majority of scientific opinion does not ensure a "fact" is "reality," it is the best one can do at any given moment.

B. AIDS: A BRIEF HISTORICAL EXAMINATION

In 1979 a physician at New York University Hospital treated two young men in succession for a rare skin cancer which normally attacked elderly men of Mediterranean origin.[6] The doctor noted that both men were homosexual but drew no conclusion from the fact.[7] On June 5, 1981, the Federal Center for Disease Control (CDC) first reported its analysis of a previously unidentified condition. This condition, which had apparently destroyed the immune systems of five healthy homosexual men, was later identified as Acquired Immune Deficiency Syndrome, or "AIDS".[8]

To date, the primary "high risk" groups in the United States have been homosexual and bisexual males,[9] male and female intravenous drug abusers,[10] male and female Haitians,[11] and

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[6] The cancer, Kaposi's Sarcoma, frequently inflicts AIDS patients. See Footnote [32] below.

[7] Mendicino, *Characterization and Disease: Homosexuals and the Threat of Aids*, 66 N.C.L. Rev. 226, (1987).

[8] Carey and Arthur, *The Developing Law on AIDS in the Workplace*, 46 Md.L. Rev. 284 (1987)

[9] Researchers firmly established the link between the incidence of AIDS and homosexual activity early in 1982. Although the Center for Disease Control initially used the terms Kaposi's sarcoma and PCP, (the two rare conditions whose increased frequency had alerted the scientific community,) the perception of the disease's relationship to homosexual activity was reflected by popular usage of the acronym GRID--Gay-Related Immune Deficiency. Mendicino, *Characterization and Disease: Homosexuals and the Threat of AIDS*, 66 N.C.L. Rev. 226 (1987).

[10] Id.

[11] "In 1982, researchers first identified recent Haitian immigrants to the United States as a high risk group for AIDS. An immediate controversy accusing the CDC of racial and socio-economic bias surrounded the classification of an

recipients of blood products.[12] Though the spread of AIDS outside these groups has been limited,[13] fear engendered by the devastating nature of the disease brought unresolved social issues relating to these groups or subcultures to the surface.[14]

Some segments of society have taken the position that infected members of high risk groups are only reaping what they have sown by their own behavior.[15] There has been a resurgence of anti-homosexual rhetoric more reminiscent of revival tent meetings than political discourse.[16] Hunting for, (and

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entire nationality as a risk group. However, the lack of any identifiable behavioral characteristics precluded inclusion of many of the Haitian cases in any of the existing risk categories. Haitian authorities asserted that there was no scientific basis to classify a nationality as being at risk for AIDS. The CDC prevailed by arguing that proper epidemiological evaluation required the creation of the category because the empirical subjects denied participating in any previously classified risk behavior while the incidence of AIDS cases per population unit was much higher in the American Haitian community than in the population of the United States as a whole." Mendicino, *Characterization and Disease: Homosexuals and the Threat of AIDS*, 66 N.C.L. Rev. 226, (1987).

[12] Id.

[13] See the chart at Appendix A

[14] One commentator has attempted to explain the widespread social "panic response" to AIDS as a function of five social taboos. The writer believes it is the fear implicit in societal taboos relating to sex, social stigma, helplessness, mental illness and death which inhibits society's ability to deal effectively with AIDS. Shulman, *AIDS Discrimination: Its Nature, Meaning and Function*, 12 Nova L. Rev. 1113, (1988).

[15] See Appendix B for the text of comments made by Representative Dornan of California before the Congress of the United States. Mr. Dornan makes it clear that he is convinced the majority of AIDS infected people have no one but themselves to blame for their illness and that these "homosexuals" have shown their inherent immorality by joining the pro-abortion movement to secure fetal tissue for AIDS research.

[16] "On May 1, 1987, an aide to Reverend Jerry Falwell disclosed that the Moral Majority was going to purchase broadcasting time to 'expose the myths and the cover-up of the facts about the AIDS epidemic.' In a related letter, Reverend Falwell attributed the 'original spawn' of the AIDS epidemic to homosexuals and alleged that 'powerful militant homosexuals' have extended their 'wretched [political] influence' to extract a "cover-up" about the disease and

apparently finding,) homosexuals under every bed, one elected official even characterized the recently passed Americans With Disabilities Act as a "last ditch attempt of the remorseless sodomy lobby to achieve its national agenda before the impending decimation of AIDS destroys its political clout."[17]

Other high risk groups have fared little better than members of the homosexual community. Some commentators have argued that the impact of poverty and minority status on the "America" one perceives is nowhere more obvious than in the cases of people with AIDS. The focus of most early organized education campaigns was on the predominantly white middle class homosexual community,[18] ignoring the ravages of the disease in minority communities.[19] It may be that the continued spread of AIDS in minority communities reflects a reluctance to confront the

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to prohibit public health officials from 'doing what needs to be done'--mandatory testing and quarantine--to halt the spread of the 'plague.'" Mendicino, *Characterization and Disease: Homosexuals and the Threat of AIDS*, 66 N.C.L.Rev. 226, (1987).

[17] Comments of Representative Burton of Indiana made on the floor of the 101st Congress, First Session, Monday, October 2, 1989. 1989 WL 185305 (Cong.Rec.) 135 Cong.Rec. H6440-01.

[18] The city of San Francisco lost almost $3 million in state funds and private grants because of a lack of minority involvement in its AIDS education planning. The San Francisco experience is not unique. The Chicago Department of Public Health has been criticized for neglecting Hispanics. The ACLU and a coalition of minority organizations have filed a lawsuit against Los Angeles County for failing to provide minority AIDS education. So, too, the Philadelphia AIDS Task Force has been publicly criticized for not networking outside its white gay base. AIDS Foundation/Houston has been attacked for racist fund raising activities." Harrington, *A Fatal Bias: AIDS and Minorities*, 14 Hum.Rts. 34 (1987) (Published by the Section of Individual Rights and Responsibilities, American Bar Association.)

[19] See Appendix C

underlying behavioral patterns which promote the spread of the disease rather than any societal bias.[20] However, whatever the cause of the epidemic in their communities, minority group members have tended to suffer more and die faster than their white, middle class counterparts.[21]

The possible re-emergence of race and other anti-minority group prejudices in the context of the AIDS debate presents difficult questions for an arbitrator. Is the terminated or disciplined employee being singled out simply because they have been exposed to the AIDS virus or for engaging in high risk activity? Has the adverse action been taken because the employer (and other employees) believe the exposed employee poses a real health danger or simply because the exposed employee belongs to a sub-group whose members are otherwise disliked? What will be the impact on the labor relations system if the

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[20] "The original assumption that AIDS was a gay disease forced denial in many segments of the minority communities. Thus, just recently when AIDS experts asked to speak to churches in the San Francisco Baptist Ministers Conference, [a group representing predominantly black congregations,] their request was denied. The acceptance of AIDS, in effect, means accepting drug abuse, prostitution, homosexuality and bisexuality in the black and Hispanic communities. Thus, societies that are stigmatized because of racism must accept the existence of a disease whose transmittal embraces conduct usually unacceptable at best and illegal at worst." Harrington, *A Fatal Bias: AIDS and Minorities,* 14 Hum.Rts. 34 (1987) (Published by the Section of Individual Rights and Responsibilities, American Bar Association.)

[21] "[t]he average life expectancy for a minority PWA is 19 weeks; for a white PWA it is two years. Black and Hispanic PWAs [people with AIDS] have less access to adequate health care, their nutrition is more unbalanced, their health insurance is less effective or non-existent, and the ability to perceive themselves at-risk and thus protect themselves and their partners are obviously less. This, in turn, means that medical intervention comes much later and is probably of a poorer quality." Harrington, *A Fatal Bias: AIDS and Minorities,* 14 Hum.Rts. 34 (1987)

employer (and other employees) are permitted to use the risk of AIDS exposure as a rationale for discriminating against members of a despised sub-group? Finally, is it the arbitrator's job to peer under the surface of the grievance to see if discriminatory motives lie at the heart of the adverse action?[22] While these "social" issues can be ignored, their implicit resolution by an arbitrator will have legal and systemic implications which may extend far beyond the given case.

C. AIDS: A BRIEF CLINICAL EXAMINATION

The Human Immunodeficiency Virus (HIV), the cause of AIDS,[23] is now estimated to infect up to two million people in

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[22] One could argue that the grievant and his or her union are free assert that the adverse action was in fact motivated by impermissible prejudice against the grievant's racial or ethnic subgroup or the grievant's sexual orientation. Similar assertions are common under Title VII and could be resolved in the same manner as allegations of "pretext" in Title VII cases. (See generally; B.Schlei & P. Grossman, *Employment Discrimination Law*, (2d ed. 1983), at pages 597-603). One could also argue that the traditional analysis used in "mixed motive" cases might be appropriate here. However, there seems little place for these approaches in the arbitration of an AIDS dispute. Allegations of pretext or mixed motive are possible only when the employer seeks to take adverse action based on conjecture or generalizations. The arbitrator who requires the employer to establish that the adverse action was predicated on the established consequences of the particular grievant's own AIDS related medical condition can base his or her decision on that evidence without fear of "hidden motivations". The key will be whether the arbitrator knows enough about AIDS to distinguish between conjecture and medical "fact".

[23] This "cause of AIDS derives from a member of a family of viruses known as retroviruses. Such viruses are prevalent in certain species of animals, but have only recently been described in human beings. In 1983, a previously unknown retrovirus later named as LAV (lymphadenopathy-associated virus), HTLV-III (human T-cell lymphotropic virus type III), or ARV (AIDS-associated retrovirus), was identified as the cause of AIDS. These early isolates of retroviruses were later recognized to be closely related; and a single name, Human Immunodeficiency Virus (HIV), was proposed for them and for subsequently isolated and related viruses." Kendellen, *Aids: A Clinical Statement*, 126 N.J. Law. 14, (1989)

the United States and millions more in other countries.[24] It has been estimated that 365,000 new AIDS cases will have been reported in the United States by 1992.[25] The virus is thought to be transmitted by intimate sexual contact, the sharing of contaminated needles, or, less commonly, by percutaneous inoculation with infectious blood or blood products.[26] While AIDS is thus communicable, there is apparently no evidence that AIDS can be transmitted by casual contact[27] or, as has been suggested by some,[28] by blood sucking insects.[29]

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[24] Kendellen, *Aids: A Clinical Statement*, 126 N.J. Law. 14, (1989)

[25] Id.

[26] Koop, *The Surgeon General's Report on Acquired Immune Deficiency Syndrome*. (1987)

[27] "Although HIV has been occasionally found in the tears and in saliva of infected individuals, the concentration and amount of virus, its viability, the lack of effective transmission and the lack of any reported cases of transmission by these means, all negate the importance of these fluids in the course of the AIDS epidemic. The fear of casual contact--handshaking, food preparation and handling and the normal interactions of the workplace--has become a significant issue. There have been nine scientific studies which completely discount the role of casual and normal human interaction as a means of HIV transmission. In addition, there have not been any 'casual contact' cases reported among the relatives and friends of the 60,000 reported AIDS cases." Margolis, *The AIDS Epidemic: Reality Versus Myth*, 72 Judicature 58, (1988).

[28] Consider the comments Representative Burton of Indiana made on the floor of the U.S. House of Representatives on Thursday June 9, 1988. Rep. Burton sharply criticized the position of the Surgeon General that AIDS was not transmitted by insects and demanded a mandatory nationwide AIDS testing program to identify and track infected individuals.

[29] "Mosquitoes have been discounted as agents for HIV transmission to humans. Belle Glade, Florida, a small town approximately 40 miles west of West Palm Beach, had the highest incidence in the United States of reported AIDS, 564 per 100,000 population. A series of medical and epidemiological studies were initiated involving more than a thousand people residing in Belle Glade, which showed that only black residents of Belle Glade and persons born in Haiti demonstrated antibodies to the AIDS virus, in a ratio of 1.3 to 1, male to female. No children, or adults above the age of 60 were found to be seropositive for the AIDS virus antibody. The comprehensive study demonstrated a localization of HIV infection in tightly defined neighborhoods, specifically among the squalid living conditions of the black residents of Belle Glade, many of whom were employed as migrant farm workers. HIV infection was shown to be associated with

There is yet no effective treatment for the underlying acquired immune deficiency.[30] As a consequence, most AIDS patients die from overwhelming infections within 2 to 3 years of the initial appearance of symptoms. In fact, the principal manifestations of AIDS can be either an opportunistic infection[31] or cancers such as Kaposi's Sarcoma.[32]

In addition to these infections and malignancies, there is

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sexually active lifestyles, prostitution and/or being born in Haiti, where heterosexual transmission of the virus has been demonstrated. Among men specifically, infection was associated with homosexual activity and intravenous drug abuse." Margolis, *The AIDS Epidemic: Reality Versus Myth*, 72 Judicature 58, (1988).

[30] "Since HIV appears to cause persistent lifelong infection, it must be approached as a member of a class of viruses for which successful treatment may be most difficult to find. In general, infectious viral agents remain a major health threat. Yet, they are difficult to treat because they are intracellular pathogens, replicating within the cells of their chosen host, and thus they compromise the activities and health of the host cells. As a member of the family of retroviruses, HIV represents a type of viral pathogen whose therapy has not been previously researched in humans." Kendellen, *AIDS: A Clinical Statement*, 126 N.J. Law. 14, (1989)

[31] "There is a typical grouping of clinical infectious syndromes and opportunistic infections in AIDS patients. Many AIDS patients experience malaise, fevers, anorexia, and weight loss for weeks, months, or years prior to the documentation of their initial opportunistic infection. These symptoms are nonspecific. AIDS patients may initially develop localized dermatomal herpes zoster (shingles) or oral candidiasis (thrush). Extension of oral candidiasis can lead to esophageal erosions, complaints of difficulty in swallowing, and a burning sensation behind the sternum. Both primary and recurrent Herpes simplex virus infections appear as painful vesicular lesions in oral, genital, and perineal areas. Macher, *Acquired Immune Deficiency Syndrome*, in Encyclopedia of Science and Technology, Volume 1, 6th Edition. See Appendix D for a more complete description of common opportunistic infections and symptoms.

[32] "Kaposi's sarcoma is a vascular tumor of endothelial cell origin and appears as firm red or violet nodules involving the skin and mucous membranes; lesions are often multiple and may involve any portion of the skin or any mucous membrane; body surfaces may eventually be covered by these multifocal tumors. Some patients develop life-threatening visceral involvement due to massive tumor infiltration of the lung or gastrointestinal tract; since they are vascular tumors, bleeding is not uncommon." Macher, *Acquired Immune Deficiency Syndrome*, in Encyclopedia of Science and Technology, Volume 1, 6th Edition. See also A. Friedman-Kien et al., *Disseminated Kaposi's sarcoma in homosexual men*, Ann. Intern. Med., 96:693-700, 1982.

evidence that the vast majority of adult AIDS patients suffer damage to the noncentral nervous system or AIDS related dementia.[33] This data suggests that the range of AIDS related neurologic and neuropshyciatric impairment may extend beyond that of AIDS itself.[34] Even more disturbing is evidence that central nervous system involvement by the HIV virus may begin early in the course of infection and cause mild cognitive defects in seropositive individuals who exhibit no other outward signs of disease.[35]

For the purposes of analysis it is useful to separate those who have been exposed to AIDS[36] into three groups. First, there

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[33] "As many as 90 percent of patients dying from HIV-related conditions have abnormalities of the nervous system at postmortem examination; the majority of patients have some clinical manifestation of neurologic disease during their lifetime. Of the HIV-related neurologic complications, dementia is among the most severe and disabling." Kenellen, *AIDS: A Clinical Statement*, 126 N.J. Law. 14, (1989).

[34] "It has been estimated that between 30 percent and 60 percent of AIDS patients will manifest a characteristic dementia syndrome, which has been designated AIDS dementia complex (ADC); that 10 percent of patients may present with neurological symptoms before developing any signs of AIDS; and that perhaps an even larger number of infected individuals may show persistent evidence of neurologic impairment in the absence of an actual diagnosis of AIDS. The AIDS dementia complex...is often marked by initially subtle cognitive or behavioral dysfunction occurring over weeks to months. Patients initially report memory loss, difficulty in concentrating, social withdrawal, and lethargy. Those early signs may often be attributed to depression and may be ignored until they eventually progress to more dramatic deficits involving severe dementia and psychomotor retardation." Hentoff, *Note, The Rehabilitation Act's Otherwise Qualified Requirement and the Aids Virus: Protecting the Public from Aids-Related Health and Safety Hazards*, 30 Ariz. L. Rev. 571, (1988).

[35] Id.

[36] "The earliest indications that HIV has been transmitted to an individual are either the isolation of HIV from that person or the detection of antibodies to the virus in the person's blood. The new appearance of antibodies, known as seroconversion, appears to predate any detectable immunologic defects (i.e., decrease in the number of T4 cells); but within five years of seroconversion evidence of immunologic defects occurs in more than 90 percent

are those who test positive for exposure to the virus but show no clinical manifestations of the disease.[37] These people may never develop AIDS Related Complex (ARC) or AIDS, but can pass the infection to others.[38] Second, there are HIV infected people who are suffer from physical symptoms related to AIDS but have not experienced the severe medical complications which characterize AIDS. These patients, suffering from what is now called AIDS Related Complex (ARC),[39] begin to experience loss of appetite, weight loss, fever, night sweats, skin rashes, diarrhea, tiredness, lack of resistance to infection, or swollen

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of individuals. Six to eight weeks is the typical time between transmission of the virus and seroconversion. In some reported instances, individuals have remained seronegative for many months, although they were infected as evidenced by cultivation of the virus in the blood. A very high proportion of individuals who are seropositive for HIV antibodies will ultimately develop AIDS." Kendellen, *AIDS: A Clinical Statement*, 126 N.J. Law. 14, (1989).

[37] "A person infected with the AIDS virus will be detectable through testing for the production of antibodies to the human immunodeficiency virus in 6 to 12 weeks from the time of infection. A very small percentage of HIV-infected people have been reported to have their antibodies not measurable for as long as 12 months from the time of infection. The HIV-infected person may or may not progress to ARC and/or AIDS. Approximately 30-50 per cent of homosexual/bisexual men infected with HIV have been diagnosed with AIDS. The incubation period (the time from infection with the virus to the diagnosis of AIDS) has been shown to vary significantly. The mean time has been reported for transfusion recipients to be as short as 2 years, for children (0-5 years of age), 5.5 years, for elderly patients (60 years and older) and for adults (5-59 years of age), 8.23 years. Preliminary results are demonstrating shorter incubation periods for male intravenous drug abusers and even shorter incubation times for infected females." Margolis, *The AIDS Epidemic: Reality Versus Myth*, 72 Judicature 58 (1988)

[38] "Even though the person infected with HIV may not be aware of that fact, either because of not being tested or not yet having measurable antibodies, they can transmit the virus. In fact, the person infected with the AIDS virus, the person who is analyzed as HIV-antibody positive, the person with ARC and the person with AIDS can all transmit the virus via their blood, semen and/or vaginal discharges throughout their lifetime." Margolis, *The AIDS Epidemic: Reality Versus Myth*, 72 Judicature 58, (1988).

[39] It is unclear whether persons with ARC will invariably develop AIDS, but the evidence seems to indicate that this may be so. Margolis, *The Aids Epidemic: Reality Versus Myth*, 72 Judicature 58, (1988).

lymph nodes.[40] Lastly, there are patients who have AIDS, that is a severe degradation of the body's immune system which renders the patient vulnerable to infection by bacteria, protozoa, fungi, and other viruses and malignancies. These infections cause life-threatening illness, such as pneumonia, meningitis, and cancer and are the cause of death for most AIDS patients.[41]

As a practical matter, arbitrators are more likely to face cases involving employees suffering from ARC and AIDS, rather than those who are infected but asymptomatic. Setting aside the possibility of AIDS Related Dementia, persons who are seropositive for the AIDS antibody but are experiencing no physical signs of disease will for the most part be indistinguishable from the larger employee group. While adverse actions based on mere seroposivity are possible, given the position of public health authorities, justification for such actions will be extremely hard for the employer to articulate.

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[40] **Koop,** *The Surgeon General's Report on Acquired Immune Deficiency Syndrome*, **The U.S. Department of Health and Human Services, (1987) For a more technical definition of ARC, see also Redfield, Markham, Salahuddin, Wright, Sarngadharan & Gallo,** *Heterosexually Acquired HTLV-III/LAV Disease (AIDS-Related Complex and AIDS)*, 254 J. A.M.A. 2094 (1985). ARC is also discussed in Jason, McDougal, Dixon, Lawrence, Kennedy, Hilgartner, Aledort & Evatt, *HTLV-III/LAV Antibody and Immune Status of Household Contacts and Sexual Partners of Persons With Hemophila*, 255 J. A.M.A. 212 (1986).

[41] **Koop,** *The Surgeon General's Report on Acquired Immune Deficiency Syndrome*, **U.S. Department of Health and Human Services, (1987).**

D. THE ROLE OF THE ARBITRATOR

The comments which follow are intended as a brief outline of the relevant principles governing the conduct of arbitration in the private labor relations context. As such, they present the basic picture without which the substantive discussion concerning the impact of AIDS on that process would not be possible. However, lengthy discussions of philosophically "hot" topics, such as the propriety of applying external law to the arbitral process[42] or the appropriate limits of the public policy exception[43], are beyond the scope of this paper.

Contractual dispute resolution in the american labor relations model normally encompasses at least three elements. First, within their collective bargaining agreement, the contracting parties, Employer and Union, establish a grievance procedure where disagreements concerning the terms of that

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[42] See generally: Howlett, *The Arbitrator, the NLRB, and the Courts,* in Proceedings of the 20th Annual Meeting, National Academy of Arbitrators, 67 (BNA Books, 1967) and Mittenthal, *The Role of Law in Arbitration,* in Developments in American and Foreign Arbitration, Proceedings of the 21st Annual Meeting, National Academy of Arbitrators, 42 (BNA Books, 1968).

[43] See generally; Magee, *The Public Policy Exception to Judicial Deferral of Labor Arbitration Awards--How Far Should Expansion Go?,* 39 SCLR 465, (1988); Berlowe, *Judicial Deference to Grievance Arbitration in the Private Sector: Saving Grace in the Search for a Well-Defined Public Policy Exception,* 42 U.Miami L.Rev. 767, January, (1988); Heinsz, *Judicial Review of Labor Arbitration Awards: The Enterprise Wheel Goes Around and Around,* 52 Mo.L.Rev. 243, (1987); Edwards, *Judicial Review of Labor Arbitration Awards: The Clash Between the Public Policy Exception and the Duty to Bargain,* 64 Chi.-Kent L. 3, (1989); Bedikian, *Riding on the Horns of a Dilemma: The Law of Contract v. Public Policy in the Enforcement of Labor Arbitral Awards,* 1988 Det. C.L. Rev. 693 (1988).

agreement are sent for resolution.[44] Next, when a grievance arises under the terms of the contract, the parties process the disagreement through the basic grievance machinery and attempt to resolve it to their mutual satisfaction.[45] Lastly, if the parties are unable to agree on a "correct" resolution of the dispute and the topic is one which the parties have agreed will be subject to arbitration, the dispute can be submitted to a neutral[46] who will interpret the contractual language for the parties and render a decision.

Arbitration plays a unique role in the process just described. In *Textile Workers Union of America v. Lincoln Mills of Alabama,*[47] the Supreme Court set the stage for the current system of dispute resolution by defining a forum for the enforcement of the provisions of collective bargaining agreements. In the so called Steel Workers Trilogy[48] the court

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[44] In the Federal sector the opportunity for binding arbitration is required to be in every collective bargaining agreement. See Title 5 USC Chapter 71, §7121(b)(3)(C).

[45] Ray, *Protecting the parties' Bargain After Misco: Court Review of Labor Arbitration Awards,* 64 Ind.L.J. 1, (1988) at Footnote 2.

[46] This fact-finder can be an independent arbitrator hired to hear a particular controversy, an arbitrator who has been hired to hear all the disputes which arise under the agreement, or a multi-person panel made up of representatives of each party and an outside arbitrator.

[47] *Textile Workers Union of America v. Lincoln Mills of Alabama,* 353 U.S. 448 (1957).

[48] *Steelworkers v. Mfg. Co.,* 363 U.S. 564, 46 LRRM 2414 (1960); *Steelworkers v. Warrior & Gulf Navigation Co.,* 363 U.S. 574, 46 LRRM 2416 (1960); *Steelworkers v. Enterprise Wheel & Car Corp.,* 363 U.S. 593, 46 LRRM 2423 (1960).

recognized the central position of the arbitration process within the labor relations model by severely limiting the scope of judicial review of arbitral decisions.[49]

The Supreme Court's treatment of arbitration reflected the Court's view of the parties' contractual relationship and the importance of the collective bargaining agreement to the maintenance of labor peace.[50] The labor relations environment is characterized by extensive daily interaction between the contracting parties. The level and nature of this interaction may be shaped as much by the political and economic strengths of the parties as it is by their purely legal rights under the contract. In addition, whatever their disagreements may be, the parties to these contracts are bound in a relationship whose continuing nature, imposed by law, is quite different from that created by other contracts.[51] The resolution of these

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[49] The Trilogy cases stand for three basic propositions which have elevated labor arbitration to the central position it now enjoys: (1) judicial review is limited to whether a particular grievance is arbitrable; (2) there is a presumption that a dispute between the parties concerning their rights under the contract is arbitrable; and (3) an arbitrator's award must draw its essence from the collective bargaining agreement. Bedikian, *Riding on the Horns of a Dilemma: The Law of Contract v. Public Policy in the Enforcement of Labor Arbitral Awards,* 1988 Det. C.L. Rev. 693

[50] "In the commercial case, arbitration is the substitute for litigation. Here arbitration is the substitute for industrial strife. Since arbitration of labor disputes has quite different functions from arbitration under an ordinary commercial agreement, the hostility evinced by courts toward arbitration of commercial agreements has no place here. For arbitration of labor disputes under collective bargaining agreements is part and parcel of the collective bargaining process itself." *United Steelworkers v. Warrior & Gulf Navigation Co.*, 363 U.S. 574, 578 (1960).

[51] Note the Supreme Court's language in *John Wiley & Sons, Inc. v. Livingston*, 376 U.S. 543, at 550 (1969): "While the principle of law governing ordinary contracts would not bind to a contract an unconsenting successor to a

disagreements by arbitration is intended to obviate the need to resort to the traditional but more disruptive dispute resolution weapons; slowdowns, strikes, lockouts and litigation.[52]

Arbitration can be viewed, institutionally, purely as a contractual enforcement mechanism. By contracting for binding arbitration, the parties have decided to have an arbitrator act as "contract reader."[53] The arbitrator's function is to tell the parties what a fair interpretation of their agreement mandates in a particular case. As discussed at length below, that opinion, to be valid, must "draw it essence"[54] from the contractual terms to which the parties have agreed.[55]

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contracting party, a collective bargaining agreement is not an ordinary contract...The collective agreement covers the whole employment relationship. It calls into being a new common law...It is not in any real sense the simple product of a consensual relationship."

[52] In *United Steelworkers of America v. American Manufacturing Co.*, 363 U.S. 564, (1960), Justice Douglas noted the policy preference for the use of arbitration in §203(d) of The Labor Management Relations Act, 1947: "Final adjustment by a method agreed upon by the parties is hereby declared to be the desirable method for settlement of grievance disputes arising over the application or interpretation of an existing collective bargaining agreement."

[53] St. Antoine, *Judicial Review of Labor Arbitration Awards: A Second Look at Enterprise Wheel and Its Progeny,* 75 MICH L. REV. 1137, 1160-61. (1977).

[54] In the third Trilogy case, *United Steelworkers v. Enterprise Wheel & Car Corp.*, 363 U.S. 574, 582-3 the Supreme Court noted the contractual basis for the arbitrator's power: "When an arbitrator is commissioned to interpret and apply the collective bargaining agreement, he is to bring his informed judgment to bear in order to reach a fair solution of a problem...Nevertheless, an arbitrator is confined to interpretation and application of the collective bargaining agreement; he does not sit to dispense his own brand of industrial justice. He may of course look for guidance from many sources, yet his award is legitimate only so long as it draws its essence from the collective bargaining agreement. When the arbitrator's words manifest an infidelity to this obligation, courts have no choice but to refuse enforcement of the award.

[55] United Steelworkers v. Enterprise Wheel & Car Corp., 363 U.S. 574, 582-3

Similarly, when one of the parties seeks court enforcement of an arbitral award, the court's role should be to ensure the parties have received the benefit of their bargain,[56] not whether, in the court's opinion, some abstract notion of industrial justice has been achieved. Unfortunately, result oriented interpretations of the substance and "penumbra" of collective bargaining agreements can and do provide fertile ground for both arbitral and judicial mischief.

The arbitration community has wrestled for decades with the "correct" placement of arbitral parameters. Two primary schools of thought have developed with a somewhat indecisive middle group encamped between the two.[57] One school has argued for a "four corners" approach to contract interpretation. The second has urged the application of external law to contract interpretation. The middle group would permit the application of external law when "required" to the parties' contractual dispute.

Under the four corners model, the arbitrator looks for the answer to the case before him[58] within the four corners of the parties' agreement without recourse to external laws or standards

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[56] See Footnote [42] above.

[57] Bedikian, *Riding the Horns of a Dilemma: The Law of Contract v. Public Policy in the Enforcement of Labor Arbitral Awards,* 1988 Det. C.L. Rev. 693, (1988).

[58] For the purposes of this paper the words "he", "him", and "his" are intended to be gender neutral; not a reflection that the arbitrator referred to is male.

not explicitly incorporated by reference[59] or otherwise submitted for consideration by the parties.[60] The parties get the benefit of their bargain, no more, no less. Unfortunately, while this model comports with a strictly contractual view of the labor relations environment and the arbitrator's charge, it can result in arbitration awards whose performance would violate the excluded but very real dictates of external law. Some commentators view this possibility as an unacceptable weakness in the model.[61]

To the adherent to the "four corner's" school this "problem" reflects the basic contractual nature of the process of which arbitration is just a part. An award which is arguably unenforceable as violative of external law gives the parties what they contracted for, no more, no less. Simply put, the arbitrator's job is to tell the parties what their agreement entitles them to claim, not to help them garner what they failed

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[59] One commentator has described four types of clauses which can be used by the parties to incorporate external law. In the first, "global incorporation" the parties use general language which obliges them to behave in accordance with the law. In the second, "particular incorporation", the parties' clause brings specific statutes or laws within the collective bargaining agreement. In the third and fourth types, "deleter" and "conformer" clauses, the parties agree that clauses which conflict with external law shall either be deleted (leaving the rest of the contract intact,) or amended to conform with external law (leaving the rest of the contract intact.) See: Oldham, *Arbitration and Relentless Legalization in the Workplace,* in Arbitration 1990 New Perspectives on Old Issues, Proceedings of the Forty-Third Annual Meeting National Academy of Arbitrators (G. Gruenberg ed. 1990)

[60] Mittenthal, *Why Arbitrators Do Not Apply External Law, in Labor Arbitration, a Practical Guide for Advocates 287 (1990).*

[61] Howlett, *Why Arbitrators Apply External Law, in Labor Arbitration, a Practical Guide for Advocates 257 (1990)*

to bargain for. If the parties' agreement doesn't entitle them to an enforceable award, they don't get one. Far from reflecting a failure of the arbitral process, the arbitrator's award enhances the collective bargaining relationship by showing the parties that their agreement contains an unenforceable provision which they may want to address when the collective bargaining agreement is re-negotiated.

The opposite camp urges the application of external law as the most productive approach.[62] Under this view, the arbitrator is employed to assist the parties in the management of their collective bargaining relationship. This school of arbitrators rejects the idea that an award which simply forces the parties to engage in costly and protracted litigation on the issue of enforceability could possibly be what the parties bargained for. Adherents of the external law view argue further that all contracts should be viewed as consistent with the regulatory environment in which they were created and therefore recourse to that external law is not only permissible, it is essential to a "correct" reading of the parties' bargain.[63] Finally, an enforceable award promotes "labor peace" by resolving the issues

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[62] Howlett, *Why Arbitrators Apply External Law, in Labor Arbitration, a Practical Guide for Advocates 257 (1990)*

[63] This view of contracts was criticized by Professor Mittenthal as highly artificial in that it assumes that everyone knows the law and everyone makes his contracts with reference to that law. Mittenthal, *Why Arbitrators do Not Apply External Law, in Labor Arbitration, a Practical Guide for Advocates 287, at 289 (1990).*

between the parties without recourse to the courts.

It can be argued that the "amendment" of labor contracts to incorporate external law reflects a tendency towards paternalism which is completely inappropriate in an ongoing contractual relationship. Like a parent who steps in whenever his child has difficulties, the arbitrator who incorporates external law removes the parties' incentive to learn from their mistakes. In the case of a collective bargaining agreement, the parties need to learn to bargain more carefully over the terms of their relationship. In response, one might argue that this whole line of attack assumes the parties did not implicitly include applicable external law. If that assumption is incorrect, the arbitrator who applies external law IS giving the parties the benefit of their bargain, (and preserving labor peace in the process.)

Is the arbitrator's award really final? Regardless of the approach taken on the application of external law, parties who receive arbitral awards they disagree with can and do refuse to abide by them.[64] The "winning" party is then forced to sue for enforcement. When this happens, the courts are injected into the

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[64] In addition to cases where finality is tested by a party's efforts to have the arbitration award overturned, there are cases where the grievant is free to ignore the arbitration decision and "re-litigate" the grievance as a violation of his or her independent rights. The most common cases where these rights arise involve alleged Title VII violations. See generally: Hoyman & Stallworth, *The Arbitration of Discrimination Grievances in the Aftermath of Gardner-Denver*, 39 Arb.J. 49 (S 1984).

labor relations process, a result the parties were presumably trying to avoid by adopting arbitration in the first place. Depending on one's perspective, this judicial intrusion either undercuts the labor relations model, (by compromising the virtues of cheapness, swiftness and finality promised by arbitration,) or enhances it, (and arbitration as a part of that model,) by ensuring that arbitral awards adhere to the larger societal interests which form the underpinnings of lasting labor peace. Whatever the perspective, litigation of arbitral awards is a reality which won't go away. What can the parties expect of the judiciary?

The Supreme Court has severely restricted the judiciary's role in the review of arbitral awards. However, there are two principal exceptions to the principle of arbitral finality. The first exception, that the arbitrator's award is fatally flawed because it does not draw "its essence" from the collective bargaining agreement the parties asked him to interpret, (noted above,) is a relatively narrow one. The basic rule seems simple. A court is bound to enforce the award and is not entitled to review the merits of the contract dispute unless the arbitrator's decision is not based on the terms of the collective bargaining agreement.[65] This remains so even when the basis for the

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[65] *United Steelworkers v. Enterprise Wheel & Car Corp.*, 363 U.S. 593, (1960).

arbitrator's decision may be ambiguous,[66] or even incorrect. As long as the arbitrator's decision even arguably construes or applies the contract and can somehow be viewed as within the scope of his authority, the fact that the court is convinced the arbitrator committed serious interpretive errors does not permit the court to overturn the arbitrator's decision.[67]

The parameters of the second exception, a court's traditional power to refuse to enforce a contract which violates "public policy," are less certain. In its decision in *W. R. Grace & Co. v. Local Union 759, International Union of Rubber Workers,*[68] the Supreme Court acknowledged these inherent equitable powers:

> If the contract as interpreted by the arbitrator violates some explicit public policy, we are obliged to refrain from enforcing it. Such a public policy, however, must be well defined and dominant, and is to be ascertained by reference to the laws and legal precedents and not from general considerations of supposed public interests.

In *United Paperworkers International Union v. Misco, Inc.,*[69] the Supreme Court reversed the Court of Appeals for the Fifth Circuit which had held that an arbitration award reinstating a worker

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[66] *W. R. Grace & Co. v. Local Union, 759, Int'l Union of Rubber Workers,* 461 U.S. 757, 764 (1983).

[67] *United Paperworkers Int'l Union v. Misco, Inc.,* 108 S. Ct. 364, 371 (1987).

[68] *W. R. Grace & Co. v. Local Union 759, International Union of Rubber Workers,* 461 U.S. 757 (1983).

[69] *United Paperworkers International Union v. Misco, Inc.,* 108 S. Ct. 364, 374 (1987).

accused of drug use violated public policy. The Court stated, "We explicitly held in W. R. Grace that a formulation of public policy based only on 'general considerations of supposed public interests' is not the sort that permits a court to set aside an arbitration award ..."[70] While this language narrows the scope of potential judicial activism, the precise source of acceptable "public policy" remains cloudy. However, it seems clear that, at a minimum, arbitration awards which require the parties to violate positive law will be refused enforcement by the courts.

E. Sources of External Law and Public Policy

The discussion above suggests that external law may shape the benefit of the parties' bargain regardless of the model the arbitrator chooses to follow. If the arbitrator believes that he must look to external law, the award will be written to incorporate the principles and direction therein.[71] If the arbitrator is an adherent to the "four corners" rule, his award

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[70] Id.

[71] But see: *Roadmaster Corp. v. Production & Maintenance Employees' Local 504*, 655 F. Supp. 1460, 1465 (S.D. Ill. 1987), aff'd, 851 F.2d 886 (7th Cir. 1988), where the court vacated part of an arbitration award because the arbitrator incorporated §8(d) of the NLRA. The arbitrator ruled against the employer citing its failure to offer to bargain with the union prior to the contract's termination and, on that specific basis, ordered the contract extended for a year. Quite understandably, the union supported the arbitrator's action urging that the contract included all applicable law in existence at the time the contract was made. In the absence of any contractual clauses incorporating external law or authorization for the arbitrator to do so, the court refused to enforce the award. The Court held that arbitrator's decision was a reflection of his own views of the law rather than his opinion of the proper interpretation of the contract. As such it exceeded the jurisdiction granted by the parties and was thus unenforceable.

may direct the parties to take action in violation of external law. However, in the latter case, the losing party can be expected to challenge the award on the grounds it contravenes public policy.[72] The challenging party will argue that the award should be refused judicial enforcement because it directs a violation of positive law, (and probably prevail.) It therefore behooves those inclined to contingency planning to identify potential sources of positive law which could be used to attack the award if it "goes to the other side."

Given this reality, it is important to briefly review the possible sources of external law or public policy which may have an impact on an AIDS related arbitrator's award. The discussion will focus first on the Vocational Rehabilitation Act of 1973 as interpreted by the courts. To what extent does it protect an AIDS infected employee for adverse action by an employer? Next, what protections do state rehabilitation statutes provide to the AIDS infected employee? Finally, to what extent does the recently passed Americans With Disabilities Act provide restrictions on adverse actions based on AIDS infection?

Section 504 of the Vocational Rehabilitation Act of 1973[73] prohibits the discrimination against any "otherwise qualified"

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[72] In the former case the losing party may to argue the arbitrator exceeded the parties' submission by an impermissible incorporation of external law. See Footnote [71] above.

[73] 29 U.S.C. §701 et seq.

handicapped person[74] solely on the basis of that handicap, by any employer which receives federal funds.[75] While it is clear that §504 does protect persons suffering from contagious disease[76], the protections afforded by §504 are limited. A

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[74] In 1974 Congress expanded the definition of "handicapped individual" for use in §504 to include "any person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment." 29 U.S.C. s 706(7)(B). As the Supreme Court noted in School Bd. V. Arlines, "The amended definition reflected Congress' concern with protecting the handicapped against discrimination stemming not only from simple prejudice, but from "archaic attitudes and laws" and from "the fact that the American people are simply unfamiliar with and insensitive to the difficulties confront[ing] individuals with handicaps." S.Rep. No. 93-1297, p. 50 (1974), U.S.Code Cong. & Admin.News 1974, p. 6400." 480 U.S. 273, at 279. The reach of this amendment was underscored by the Court in Footnote 4:

> This subsection includes within the protection of sections 503 and 504 those persons who do not in fact have the condition which they are perceived as having, as well as those persons whose mental or physical condition does not substantially limit their life activities and who thus are not technically within clause (A) in the new definition.
>
> Members of both of these groups may be subjected to discrimination on the basis of their being regarded as handicapped"); id., at 37-39, 63-64; see also 120 Cong.Rec. 30531 (1974) (statement of Sen. Cranston)."

[75] §503 requires employers receiving federal contracts or subcontracts in excess of $2,500.00 to take affirmative action to employ and advance qualified handicapped people in employment and §504 of the Rehabilitation Act provides that "No otherwise qualified handicapped individual in the United States, as defined in section 706(7) of this title, shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance..."

[76] The Supreme Court spoke directly to this point in *School Bd v. Arlines*, a case brought under §504 involving a teacher with recurrent tuberculosis:

> The Act is carefully structured to replace such reflexive reactions to actual or perceived handicaps with actions based on reasoned and medically sound judgments: the definition of "handicapped individual" is broad, but only those individuals who are both handicapped and otherwise qualified are eligible for relief. The fact that some persons who have contagious diseases may pose a serious health threat to others under certain circumstances does not justify excluding from the coverage of the Act all persons with actual or perceived contagious diseases. Such exclusion would mean that those accused of being contagious would never have the opportunity to have their condition evaluated in light of medical evidence and a determination made as to whether they were "otherwise qualified." Rather, they would be vulnerable to discrimination on the basis of mythology--precisely the type of injury Congress sought to prevent. We conclude that the fact that a person with a record of a physical impairment is also contagious does not suffice to remove that person from coverage under s 504.

handicapped person is only "otherwise qualified" if he can perform the essential functions of the job in spite of his handicap.[77] Covered employers and program administrators are required to make a reasonable accommodation for an employee or applicant.[78] However, reasonable accommodation does not require the employer to make fundamental alterations in a job for a disabled employee who cannot perform the tasks required by the job he was hired to fill.[79] In addition, a worker who poses a

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480 U.S. 273, at 285, (1987)

[77] To decide whether a given person is "otherwise qualified for within the meaning of the Act will require the court to make an individualized inquiry with appropriate findings of fact. As the Supreme Court noted in *School Bd. v. Arlines*, 480 U.S. 273, 107 S.Ct. 1123, (1987) "such an inquiry is essential if §504 is to achieve its goal of protecting handicapped individuals from deprivations based on prejudice, stereotypes, or unfounded fear, while giving appropriate weight to such legitimate concerns of grantees as avoiding exposing others to significant health and safety risks. In the context of the employment of a person handicapped with a contagious disease, we agree with amicus American Medical Association that this inquiry should include:

> "Findings of facts, based on reasonable medical judgments given the state of medical knowledge, about (a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm."

[78] In the employment context, an otherwise qualified person is one who can perform "the essential functions" of the job in question. 45 CFR §84.3(k) (1985). When a handicapped person is not able to perform the essential functions of the job, the court must also consider whether any "reasonable accommodation" by the employer would enable the handicapped person to perform those functions. *School Bd. v. Arlines*, 480 U.S. 273, 288, 107 S.Ct. 1123, 1131 (1987).

[79] As the Supreme Court noted in *School Bd. v. Arline*, 107 S.Ct. 1123 1131-32, Footnote 17 (1987):

> Accommodation is not reasonable if it either imposes "undue financial and administrative burdens" on a grantee, *Southeastern Community College v. Davis*, supra, at 412, 99 S.Ct., at 2370, or requires "a fundamental alteration in the nature of [the] program" id., at 410. See 45 CFR s 84.12(c) (1985) (listing factors to consider in determining whether accommodation would cause undue hardship); 45 CFR pt. 84, App. A, p. 315 (1985) ("where reasonable accommodation does not overcome the effects of a person's handicap, or where reasonable accommodation causes undue hardship to the employer, failure to hire or promote the handicapped person will not be considered discrimination"); *Davis*, supra, at 410-413, 99 S.Ct., at 2369-2370; *Alexander v. Choate*, 469 U.S., at 299-301, and n. 19, 105 S.Ct.,

significant risk of communicating an infectious disease to others in the workplace will not be "otherwise qualified" if reasonable accommodation will not eliminate that risk."[80] Whether the employer can rely on his own "expert" to resolve the issue remains an open question.[81]

There has been a great deal of commentary concerning the application of §504 to people who are infected with the AIDS virus, with most writers coming down on the side of coverage.[82] While the Supreme Court has not spoken on the issue,[83] The Ninth Circuit has held that AIDS is a handicap within the meaning of §504.[84] It is sufficient for the purposes of this discussion to note that discharges or adverse actions against an AIDS infected employee may violate §504. The parties (and their arbitrator)

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at 720, and n. 19; *Strathie v. Department of Transportation*, supra, at 231 *Southeastern Community College v. Davis*, 442 U.S. 397, 406 (1979).

[80] *School Bd. v. Arlines*, 480 U.S. 273, 107 S.Ct. 1123 Footnote [16] (1987).

[81] The issue was reserved by the Court in *School Board v. Arlines*, at Footnote 18: "This case does not present, and we do not address, the question whether courts should also defer to the reasonable medical judgments of private physicians on which an employer has relied."

[82] See Appendix E for a listing of articles commenting on the application of §504 to AIDS related employment disputes.

[83] The court reserve this issue in Footnote [7] of it decision in *School Board v. Arlines*: "This case does not present, and we therefore do not reach, the questions whether a carrier of a contagious disease such as AIDS could be considered to have a physical impairment, or whether such a person could be considered, solely on the basis of contagiousness, a handicapped person as defined by the Act."

[84] *Chalk v. United States District Court, Central District of California*, 832 F.2d 1158 (9th Cir. 1987).

should recognize that resolution of this issue in a particular case will be fact-specific. Key elements will be the status of the employer, the ability of the employee to perform the tasks for which he was hired, the real danger to other employees, and the ability of the employer to accommodate the employee in a way which sufficiently protects others from disease or injury.[85]

State and local governments have reacted to the AIDS epidemic in a number of ways. There have been efforts to enact criminal laws restricting behavior which can spread the disease[86], to amend existing laws to include testing for AIDS[87]

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[85] In the case of AIDS, the critical question may NOT be whether the employee can infect other employees with the HIV virus. The real question may be whether the employee poses a danger due to an opportunistic infection which IS communicable by casual contact. Additional questions are posed by the onset of AIDS Related Dementia, the impact of which may pose the danger of catastrophic loss in some work environments. See generally, Hentoff, *The Rehabilitation Act's Otherwise Qualified Requirement and the AIDS Virus: Protecting the Public From AIDS-Related Health and Safety Hazards*, 30 Ariz. L. Rev. 571, (1988). For further discussion of this issue see Footnote [124] and accompanying text below.

[86] See generally: Stansbury, *Deadly and Dangerous Weapons and Aids: The Moore Analysis is Likely to be Dangerous*, 74 Iowa L. Rev. 951 (1989); Milhizer, *AIDS Update*, 27-50-195 Army Law. 29, (1989); Milhizer, *Legality of the 'Safe-Sex' Order to Soldiers Having AIDS*, (1988); Schechter, *AIDS: How the Disease is Being Criminalized*, 3 Crim.Just. 6, (1988); Washington, *Preventive Detention: Dangerous Until Proven Innocent*, 38 Cath.U.L.Rev. 271 (1988); Shelley, *Maternal substance Abuse: The Next Step in the Protection of Fetal Rights?*, 92 Dick. L. Rev. 691, (1988); Wells-Petry, *Anatomy of an AIDS Case: Deadly Disease as an Aspect of Deadly Crime*, 27-50-181 Army Law. 17, (1988); Schultz, *AIDS: Public Health and the Criminal Law*, VII St. Louis U.Pub.L.Rev. 65 (1988);Joseph, Jr., *Criminal Procedure*, 48 La.L.Rev. 257 (1987); Robinson, Jr., *AIDS and the Criminal Law: Traditional Approaches and a New Statutory Proposal*, 14 Hofstra L. Rev. 91 (1985).

[87] See Spaht, *Revision of the Law of Marriage: One Baby Step Forward*, 48 La.L.Rev. 1131, (1988), which notes the new requirement for AIDS testing before marriage.

and to re-examine the state's power to quarantine its citizens.[88] On the other hand, forty five states have civil rights laws which provide protection against discrimination based on a handicap. Of these, thirty three have either specific rulings or informal indications from state enforcement agencies that people infected with AIDS are protected from discrimination by state civil rights laws.[89] Several large cities have passed similar protections.[90]

Lastly, the parties ought to consider the provisions of the Americans with Disability Act of 1990. Though most of its provisions are not binding until July 1992, the Act will

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[88] See generally, Gostin, *The Politics of AIDS: Compulsory State Powers, Public Health, and Civil Liberties*, 49 Ohio St.L.J. 1017 (1989); Fallone, *Preserving the Public Health: a Proposal to Quarantine Recalcitrant AIDS Carriers*, 68 B.U.L.Rev. 441 (1988); Merritt, *Communicable Disease and Constitutional Law: Controlling AIDS*, 61 N. Y. U. L. Rev. 739 (1986); Parmet, *AIDS and Quarantine: the Revival of an Archaic Doctrine*, 14 Hofstra L.Rev. 53 (1985).

[89] *Epidemic of Fear, A Guide to the Legal Problems of People With AIDS*, Published by the LAMBDA Legal Defense Fund. (1990) See Appendix F for a further breakdown of state anti-discrimination statutes.

[90] "A San Francisco ordinance, effective December 20, 1985, prohibits discrimination based on the fact that a person has or is perceived to have AIDS. This prohibition extends to employment, housing, public accommodations, educational institutions, and city facilities. San Francisco, Cal., Ordinance No. 49,985 (Dec. 20, 1985)., reprinted in 3 Empl. Prac. Guide (CCH) p 20,950B (Dec. 1985). On August 16, 1985, a Los Angeles public ordinance prohibiting employment discrimination against persons perceived to have AIDS and persons with AIDS or AIDS-related conditions became effective. LOS ANGELES, CAL., MUNICIPAL CODE ch. 4, art. 5.8 (1985). Mayor W. Wilson Goode of Philadelphia issued an Executive Order on April 15, 1986, prohibiting discrimination against persons with AIDS for the purposes of employment and service. The order was based on new medical information that AIDS is not communicable by casual contact and on a city solicitor's opinion that determined AIDS to be a handicap. On December 11, 1986, the City Council of Austin, Texas passed a broad ordinance banning AIDS discrimination in employment, housing, and public accommodations. The ordinance extends protection to persons with AIDS and ARC as well as to individuals who are seropositive or who are perceived to be at risk of contracting the disease. Carey and Arther, *The Developing Law of AIDS in the Workplace*, 46 Md. L. Rev. 284, (1987).

initially cover all private employers with 25 or more employees.[91] The sweeping nature of some provisions ensures the Act will exert a major impact on the american workplace.

On it face, the basic prohibition of the Act seems simple and not much broader than that the Vocational Rehabilitation Act of 1973:[92]

> SEC. 102. DISCRIMINATION.
> (a) GENERAL RULE.--No covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment.[93]

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[91] The Act provides at Title I, §101.(5)(A):
(5) EMPLOYER.
(A) IN GENERAL.--The term "employer" means a person engaged in an industry affecting commerce who has 15 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, and any agent of such person, except that, for two years following the effective date of this title, an employer means a person engaged in an industry affecting commerce who has 25 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding year, and any agent of such person.

(B) EXCEPTIONS.--The term "employer" does not include--
(i) the United States, a corporation wholly owned by the government of the United States, or an Indian tribe; or
(ii) a bona fide private membership club (other than a labor organization) that is exempt from taxation under section 501(c) of the Internal Revenue Code of 1986.

[92] "No otherwise qualified individual with handicaps in the United States, as defined in section 706(8) of this title, shall, solely by reason of her or his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service." 29 U.S.C. §794 (a)

[93] 104 Stat 331-332 (1990)

The Act uses much the same language as the Vocational Rehabilitation Act of 1973, with protections extended to all "qualified individual(s)[94] with a disability[95]" as that term is defined by the Act. Concepts such as "reasonable accommodation"

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[94] §101.(8) The term "qualified individual with a disability" means an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires. For the purposes of this title, consideration shall be given to the employer's judgment as to what functions of a job are essential, and if an employer has prepared a written description before advertising or interviewing applicants for the job, this description shall be considered evidence of the essential functions of the job. 101 Stat 327, 331

[95] §3.(2) DISABILITY.--The term "disability" means, with respect to an individual--
(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;
(B) a record of such an impairment; or
(C) being regarded as having such an impairment.

This language is modified by that of §511, which purports to expressly exclude a number of "conditions" from the expansive definition of disability:

(a) HOMOSEXUALITY AND BISEXUALITY.--For purposes of the definition of "disability" in section 3(2), homosexuality and bisexuality are not impairments and as such are not disabilities under this Act.
(b) CERTAIN CONDITIONS.--Under this Act, the term "disability" shall not include--
(1) transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders;
(2) compulsive gambling, kleptomania, or pyromania; or
(3) psychoactive substance use disorders resulting from current illegal use of drugs.
However, when these sections are read together, the statute's definition of disability raises more questions than it answers. What does §3.(2)(C), as modified, really mean? While the act requires the employee/ applicant to prove he was discriminated against because he was "regarded" as having an impairment, (as did the Rehabilitation Act of 1973,) how does the "AIDS related" employee/applicant do this? Assume an applicant is a homosexual who is refused a job on that basis. A claim under the ADA seems barred by §511. What if, despite the express language of §511, the applicant sues under the ADA and asserts he was discriminated against not because he is a homosexual, but because employers (and society,) regard all homosexuals as AIDS carriers. Does he now have a disability claim under §3.(2) which can get to the trier of fact? Recognizing the controversy concerning AIDS and the widespread discrimination against members of high risk groups, how does the employer rebut such an assertion? Given the sociology of AIDS, are the exclusions under §511 merely a prescription for litigation?

and "undue hardship,"[96] familiar under the Vocational Rehabilitation Act of 1973, make their appearance here as well with definitions reflecting the parameters worked out in litigation under the older statute.[97] However, the term "discriminate" has been defined in an extremely broad manner arguably including people who have no disability at all.[98] As such, the Act could be source of positive law/public policy for large numbers of grievants who don't get the answer they want from the arbitrator.[99]

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[96] See Appendix G for the definitions of these terms under the Americans With Disabilities Act (ADA). While these concepts were originally developed in cases involving the accommodation of religious practices, protections are much broader under the ADA. For a review of "reasonable accommodation" and "undue hardship" in the resolution of religious practice grievances, see Helburn & Hill, *The Arbitration of Religious Practice Grievances*, 39 Arb.J. 3 (J 1984).

[97] Due to their length, those definitions are set out in Appendix G. Note however that reasonable accommodation under the Americans With Disabilities Act includes "job restructuring, part-time or modified work schedules and reassignment to a vacant position," things never required under the Rehabilitation Act of 1973. If a person must have their job restructured, made part time, or even request re-assignment to function, can the person really be said to be "otherwise qualified" for the job for which he was hired? At what point does the "restructured" job become a "new" job; part of a privately funded welfare system created by the legislature to provide income and benefits for the disabled employee?

[98] See Appendix G for the full list of activities which the Act defines as "discrimination". Most interesting is the inclusion of §102.(b)(4):

(4) excluding or otherwise denying equal jobs or benefits to a qualified individual because of the known disability of an individual with whom the qualified individual is known to have a relationship or association;

What makes this provision interesting is that it identifies, as discriminatory, acts against persons who are arguably excluded from the basic protections of §102. To come within the prohibition of that section, a person has to be a "qualified individual *with a disability.*" Is this just a restatement of §3.2? If it isn't, who would fit under this § and not under the umbrella of §3.(2)? (See Footnote [95] for a discussion of §§3.(2) and 511.) 101 Stat 327, 331

[99] In this context, I intend "source of positive law/public policy" to refer to grounds for appealing the arbitrator's decision in the courts. However, the Americans With Disabilities Act could also change the parties' rights and obligations under contracts which contain incorporation clauses. See Footnote

F. EXPECTED DISPUTES AND SUGGESTED SOLUTIONS UNDER THE TWO MOST COMMON ARBITRATION MODELS

The purpose of this section will be to identify the AIDS related situations the arbitrator should expect to encounter and suggest solutions based upon the facts and law discussed to this point. In an effort to resist the temptation to "take sides" in the dispute over the propriety of applying external law in arbitration decisions, I will pose solutions from the point of view of both arbitration models. Published arbitration decisions concerning AIDS issues are few.[100] As a consequence, I will use non-AIDS disability decisions when necessary to indicate the positions taken by arbitrators in the past on these or similar issues.

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[59] above for a brief discussion of the various types of incorporation clauses used in collective bargaining agreements.

[100] See: Hauck, *AIDS and Arbitration,* 1990 Lab. Law J. 293 In the only published article devoted to this topic, Professor Hauck argues that arbitrators "support the fundamental premise that most AIDS victims can and should continue to work until they are no longer able to meet reasonable performance standards." Professor Hauck's discussion is limited to eleven arbitration decisions. Four of these decisions dealt with the discharge of AIDS victims and seven dealt with disputes premised on employee/employer fears of AIDS. Unfortunately, Professor Hauck's description of these decisions is somewhat misleading. For example, in his discussion of In re Nursing Home, 88 Lab. Arb. (BNA) 681 (1987) Professor Hauck informs the reader that the discharge of the AIDS infected nursing home worker was overturned (at page 279.) While this may be so, what Arbitrator Sedwick really did was place the employee on suspension until "he no longer had a communicable disease." (Which, absent a sudden and unexpected medical breakthrough, would never occur.) What the grievant really got was the payment of medical bills which should have been covered while he was place on medical leave and the right to purchase medical insurance while on suspension. An examination of the other discharge cases reveals the arbitrators' decisions were based upon more traditional "good cause" principles rather than adherence to Professor Hauck's "fundamental premise." For a more general discussion on AIDS issues in the workplace see R. Stein, *AIDS in the Workplace, Opportunities for Cooperation,* In Proceedings of New York University, Forty-Second Annual Conference on Labor, (B. Stein ed. 1989), and R. Stein, *Strategies for Dealing With AIDS Disputes in the Workplace,* 42 Arb.J. 21 (S 1987).

1. ABSENTEEISM

AIDS, like any other illness, can result in lost production time for the employer. Traditional sick leave can accommodate the normal doctor's visits which may be required by the HIV seropositive employee. However, if that employee progresses to AIDS Related Complex or AIDS itself, the employer can expect substantial absences as the employee's symptoms become more severe.[101] What standards should the arbitrator apply if an employer discharges an employee due to AIDS related absences?

Historically, a majority of arbitrators have adhered to the view that discharge is warranted for chronic, excessive absenteeism even where such absences are caused by the employee's illness.[102] This view has usually been predicated on the contractual implementation of "no fault" absence provisions which the majority of arbitrators have found to be "reasonable in principle."[103] Recent decisions have upheld discharges in absence cases involving industrial injuries,[104] alcoholism,[105]

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[101] See Footnotes [36] through [41], the accompanying text above and Appendix D

[102] Block and Mittenthal, *Arbitration and the Absent Employee*, proceedings of the 37th Annual Meeting of the National Academy of Arbitrators (1984), at pages 90-91.

[103] Id. at pages 99-101

[104] See *In re T. MARZETTI COMPANY*, 91 Lab. Arb. (BNA) 154, FMCS Case No. 88/00718, (1988) in which Arbitrator Calvin William Sharpe found the Grievant's excessive-absenteeism discharge, (in which industrial-injury absences accounted for six of 10.5 points that triggered action,) did not violate public policy. This decision was reached despite existence of a state industrial commission

depression,[106] tendency to injury,[107] drug use.[108] However,

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resolution which interpreted state law to require absentee control programs to exclude absences resulting from work-related injuries. The decision noted the state commission was not authorized to interpret state law, that the commission resolution would not constitute "legal precedent," and that state courts had not ruled against such discharges. See also *NORTH RIVER ENERGY CO.*, 88 Lab. Arb. (BNA) 447 (January 12, 1987) where Arbitrator Fred Witney upheld the employer's application of the contractual "excessive excused absences" program to employee who had been continuously off work and collecting worker's compensation for 15 months following an on-the-job back injury. Factors in the arbitrator's decision were the opinions of two neurosurgeons who had agreed that employee was fit for work, the fact that the state had discontinued the grievant's worker's compensation benefits on basis of the neurosurgeons' findings, the fact the employee's absences for excused personal illness during next two months were six times workplace average, and the employer's warning to the grievant that he might be placed in the excessive excused absence program.

[105] See: *In re MICHIGAN DEPARTMENT OF SOCIAL SERVICES*, 84 Lab. Arb. (BNA) 1030, AAA Case No. 54 39 0898 83, April 29, 1985 in which Arbitrator David T. Borland upheld the discharge of an alcoholic who refused to enroll in hospital in-patient program for treatment and also refused supervisors' extended efforts to facilitate his treatment. The employee was discharged despite fact that there were no performance problems cited on days that he actually worked. The employer's rational, accepted by the arbitrator was that the employee's ability to perform in consistent manner throughout his employment had become tenuous and sporadic.

[106] In *SAFEWAY STORES*, 94 Lab. Arb. (BNA) 851, decided May 9, 1990, Arbitrator Paul D. Staudoha upheld the discharge of an employee whose leave of absence exceeded permissible 18 months. In this case the employee had stopped working because he was ill with depression. The reports of three psychiatrists had not given full clearance for return to work. See also *INTERNAL REVENUE SERVICE*, 85 Lab. Arb. (BNA) 212 (June 26, 1985) where Arbitrator Benjamin M. Shieber sustained the discharge of a grievant whose absence was due to her "major depressive reaction." Arbitrator Shieber held that grievant's removal would enable agency to fill position with dependable employee who is available for work and thereby contributes to ability of agency efficiently to accomplish its mission.

[107] In *MEAD PAPER*, 91 Lab. Arb. (BNA) 52, (May 16, 1988) Arbitrator Earl M. Curry Jr. upheld the discharge of an "accident-prone" employee. Arbitrator Curry agreed that the employee was unsuitable for work in paper mill as he had suffered 10 times more injuries than similarly situated co-workers, his accident and illness-related absences comprised almost one quarter of his 18 years of employment, and pattern was likely to continue. See also *In re ROADWAY EXPRESS*, 87 Lab. Arb. (BNA) 465, (July 31, 1986) in which Arbitrator Charles P. Chapman allowed the employer in a discharge action to submit evidence of excessive workers' compensation claims to justify the discharge based on employee's "overall work record including attendance and injuries." Arbitrator Curry noted that neither state law nor collective bargaining contract barred such evidence and the employee had shown no past practice of exclusion by grievance panels at local, state, or regional level. The arbitrator held that the disputed evidence would permit the grievance panel to determine whether employee was capable of performing job effectively as any other employee.

[108] See *BI-STATE DEVELOPMENT AGENCY*, 88 Lab. Arb. (BNA) 854, (March 17, 1987) (Arbitrator John J. Brazil).

failure to follow proper procedures have resulted in reinstatement in similar cases.[109]

Arbitrators seem to be applying a rough balancing test in absenteeism cases. On one side are the interests of the ill or injured employee and on the other the interests of the employer to have some degree of control over the number of employees who will be present on any given production day. In general, if the employee can't come to work with regularity, his discharge will be upheld regardless of the reason for the absenteeism. While some consideration is given for periods of absenteeism which are due to work related injury, even these cases result in discharge if the employee fails to "recover" in a reasonable time.[110]

Is there any need to apply a different standard in cases where the reason for "excessive" absenteeism is an AIDS related illness? For the arbitrator who is restricted to the terms of the agreement before him, the answer is no. The arbitrator

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[109] See: *PACIFIC BELL*, 91 Lab. Arb. (BNA) 653 (July 14, 1988) Arbitrator Walter N. Kaufman reinstated a diabetic employee who had three periods of disability absence during her five years of employment. Arbitrator Kaufman decided the employee was discharged improperly under attendance plan which provided that three or more disability absences within six years were unacceptable. (employer failed to investigate fully and consider the "likelihood" of future reliable service and the employer failed to obtain a current medical opinion concerning whether the grievant's diabetes was under control.) See also *WEYERHAEUSER COMPANY*, 88 Lab. Arb. (BNA) 270, (January 7, 1987) Arbitrator Francis E. Kapsch Sr. vacated the excessive absenteeism motivated discharge for six months on condition that the grievant, (who had good record over 26 years except for absences due to acute depression and treatment,) continue medical treatment and accept re-employment to his former position or any other position he was otherwise qualified to perform.

[110] See *NORTH RIVER ENERGY CO.* 88 Lab. Arb. (BNA) 447 (January 12, 1987) (Arbitrator Fred Witney) discussed in Footnote [104] above.

should treat the AIDS related absence as he would any absence case arising under the collective bargaining agreement. Under a "no-fault" absenteeism policy, the AIDS sufferer is no better (or worse) off then any other ill or injured employee. Given the nature of the disease's likely progression, discharge in the case of an AIDS patient is inevitable. In this respect the plight of the AIDS infected employee is most analogous to that of employees stricken with degenerative diseases such as multiple sclerosis, severe rheumatoid arthritis, diabetes or emphysema.

For the arbitrator who believes he is entitled to incorporate external law, the decision is less clear. As discussed above,[111] The Vocational Rehabilitation Act of 1973, state and local "disability" statutes and the Americans' with Disabilities Act contain provisions which may restrict the discharge of an employee who begins to experience AIDS related absences. The arbitrator who seeks to follow external law, (either to insulate the decision from reversal on public policy grounds or to "save the parties" from future litigation,) should conduct an inquiry into the precise nature of the absences and whether "reasonable accommodation" would result in their technical cessation. If the answer is yes, a prudent view of the law suggests the employee should be retained.

As a practical matter the infected employee's absences will

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[111] **See Footnotes [73] through [98] and accompanying text.**

continue. What will change is their characterization under the collective bargaining agreement. With "reasonable accommodation," (either job restructuring or the institution of a flexible schedule,) the impact of the absences on the employer's operation will be lessened and the final day of reckoning postponed.[112]

2. REFUSAL TO WORK (HEALTH AND SAFETY)

Employees who feel their working conditions pose an unreasonable risk of harm may have the right under federal law to refuse to perform that work.[113] However, the employee must, in good faith, reasonably believe the task assigned poses a real danger of death or serious injury or the "disobedience" is unprotected.[114] Employees who refuse to work under such

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[112] For the pattern of arbitration in absenteeism cases generally, see the graph at Appendix H.

[113] This "right" can be derived from two sources; the Occupational Safety and Health Act of 1970, 29 USC §§ 651-678 and §502 of the Labor-Management Relations Act, 29 USC §143.
Gombar, *AIDS in the Workplace: Selected Legal Issues*, 350 Prac.L.Inst. 103, (1988).

[114] The Occupational Safety and Health Act of 1970, 29 USC §§ 651-678 establishes two employer duties, A specific duty under §654(a)(2) to comply with all occupational safety and health standards promulgated by the government and a general duty under 29 USC §654(a)(1) (the "general duty clause") to furnish employment and a place of employment "free from recognized hazards that are causing or are likely to cause death or serious physical harm". Employees who in good faith reasonably believe the task assigned poses a real danger of death or serious injury may, after first seeking correction of the health hazard from the employer, refuse to subject themselves to the risk. Under these circumstances, OSHA prohibits an employer from taking any adverse action against such an employee. Gombar, *AIDS in the Workplace: Selected Legal Issues*, 350 Prac.L.Inst. 103, (1988). For a review of arbitration standards in OSHA related grievances see Wolfson, *Arbitration and OSHA*, 38 Arb.J. 12 (S 1983).

circumstances bear the burden of showing, by "ascertainable, objective evidence," that conditions exist which justify the refusal to work.[115]

A review of reported arbitral decisions since 1945 indicates this is a difficult burden indeed. In the vast majority of cases involving refusals to work for reasons of health and safety, the employees' grievances were denied by the arbitrator.[116] In cases involving disease and disability, the grievances were denied in over ninety percent of the cases.[117]

Given the controversy surrounding the AIDS epidemic,[118] it is not surprising that there have been instances where employees have filed grievances in connection with tasks which they have

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[115] §502 of the Labor-Management Relations Act, 29 USC §143, which permits employees acting in good faith to refuse to work under "abnormally dangerous conditions". In order to be protected for a work refusal predicated on §502 of the LMRA however, the employees must be able to demonstrate by "ascertainable, objective evidence" that they were or were about to be exposed to "abnormally dangerous conditions". Gateway Coal Co. v. United Mine Workers, 414 U.S. 368 (1974). Gombar, *AIDS in the Workplace: Selected Legal Issues*, 350 Prac.L.Inst. 103, (1988).

[116] See Appendix I for tables derived from a 1985 study of grievance outcomes in health and safety cases from 1945 to 1984. Gross and GreenField, *Arbitral Value Judgements in Health and Safety Disputes, Management Rights Over Workers' Rights*, 34 Buffalo L.Rev. 645 (1985). (Appendix)

[117] See Appendix I for tables derived from a 1985 study of grievance outcomes in health and safety cases from 1945 to 1984. Gross and GreenField, *Arbitral Value Judgements in Health and Safety Disputes, Management Rights Over Workers' Rights*, 34 Buffalo L.Rev. 645 (1985). (Appendix) See also Leap, Srb & Petersen, *Health and Job Safety: An Analysis of Arbitration Decisions*, 41 Arb.J. 41 (S 1986), devoted primarily to health related job safety issues.

[118] See Footnotes [14] through [21] and accompanying text above.

felt put them at risk of infection.[119] However, the reported cases indicate that establishing the "reasonable belief" that the task poses real danger of death or serious injury is no easier in the AIDS context than it has been generally. The decisions of arbitrators in these few reported AIDS cases reflects their insistence, in keeping with the standards noted above, that the grievant make a showing of objective proof that AIDS is generally communicable by the kinds of casual conduct which occur in the workplace.[120] Given the current position of medical

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[119] See: *STATE OF DELAWARE, DEPT. OF CORRECTIONS*, 86 Lab. Arb.(BNA) 849, AAA Case No. 14 390 1407 85 J, (Jan. 21, 1986) Arbitrator Lewis M. Gill found the employer had a violated contract provision requiring notification to union and prison guards of inmates who had, or were "medically suspected" of having communicable disease when it refused to disclose names of inmates who had tested "positive" for AIDS. This decision reflected an accommodation to the fears of employees rather than any finding that the asymptomatic tested prisoners posed a real danger to bargaining unit members.; *STATE OF MINNESOTA, DEPT OF CORRECTIONS*, 85 Lab. Arb. (BNA) 1185, Case No. 85M-XVI-600-3183 (Dec. 5, 1985) Arbitrator Thomas P. Gallagher reinstated a guard who had refused to obey an order to conduct pat search of inmates because of fear of AIDS contamination. The arbitrator found the discharge overly harsh given the atmosphere of panic created in part by the warden's pronouncements and the failure to provide AIDS education which might have dispelled the employee's "unreasonable" apprehension.; *IN RE VETERAN'S ADMINISTRATION*, 94 Lab.Arb. (BNA) 169, FMCS Case No. 89/23187, (Feb. 6, 1990) Arbitrator Frank J. Murphy denied demands by night maintenance employees (who cleaned federal medical-center room in which AIDS-causing human immunodeficiency virus was kept and HIV research was conducted) for environmental differential pay allowed by federal regulations for duties involving either "high degree hazard," (eight-percent differential) or "low degree hazard" (four percent). The arbitrator noted that the work was not performed "with or in close proximity to micro-organisms" so as to involve "potential personal injury," or "potential for personal injury."

[120] If an employee does contract disease in the workplace, the employer may find himself liable. However, most state worker's compensation statutes exclude disease unrelated to the employee's particular occupation. Under these circumstances the employer whose worker contracts AIDS on the job may be liable under traditional tort law with its more generous compensation levels. On the other hand, the employee's predisposition or vulnerability may be a defense. Consider the following cases; *Anderson v. General Motors Corporation*, 442 A.2d 1359 (Del. 1982), Industrial Accident Board denied claim for occupational disease benefits. The state Supreme Court held that claimant failed to establish by substantial competent evidence that his ailment, allergic rhinitis, resulted from the peculiar nature of his employment at automobile assembly facility rather than from his own peculiar predisposition; *Esposito v. Willowbrook State School*, 329 N.Y.S.2d 355, (1972) The state Supreme Court, Appellate Division, held that award for disability resulting from occupational disease could not be sustained

authorities[121] and the apparent deference of the courts to that position,[122] it is difficult to imagine how an employee in the average workplace[123] could justify a refusal to work with an HIV positive co-worker based on a fear of HIV infection.

Fellow employees could assert that the continued employment of the AIDS infected worker presents a "real danger of death or serious injury" due to the presence of his opportunistic infections (and not the AIDS virus itself.) Unlike the HIV

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where claimant, who allegedly contracted hepatitis while employed as food service worker at state school for mentally retarded, was employed at school for only a day and a half, there was no proof that claimant came in contact with a particular patient or patients suffering from infectious hepatitis and only competent evidence that any patient was suffering from disease was hospital director's letter stating that such disease was endemic at school; *McCarthy v. State Dept. of Social and Health Services*, 730 P.2d 681 (WA 1986) Employee who alleged that her employment required her to work in office environment in which she was regularly exposed to tobacco smoke and that as a result of her exposure to tobacco smoke she developed obstructive lung disease leading to her terminating her employment stated claim for negligence if employee's disease was not occupational disease within exclusive coverage of Industrial Insurance Act. However, exclusive remedy provisions of Industrial Insurance Act generally bar private causes of action only when particular disease is within coverage provisions of Act.

[121] See Footnotes [26] through [29] and accompanying text above.

[122] In its discussion of the implementation of the Rehabilitation Act of 1973, The Supreme Court noted "such an [medical] inquiry is essential if §504 is to achieve its goal of protecting handicapped individuals from deprivations based on prejudice, stereotypes, or unfounded fear, while giving appropriate weight to such legitimate concerns of grantees as avoiding exposing others to significant health and safety risks. In the context of the employment of a person handicapped with a contagious disease, we agree with amicus American Medical Association that this inquiry should include:

"Findings of facts, based on *reasonable medical judgments given the state of medical knowledge*, (emphasis added) about (a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm." *School Bd. v. Arlines*, 480 U.S. 273, 107 S.Ct. 1123, (1987)

[123] See the discussion in footnote [2] above concerning workplaces characterized by exposure to blood or other bodily fluids.

virus, it could be argued that these infections may be transmitted by casual contact.[124] However, this approach adds nothing to the debate. The arbitrator who follows the traditional principles discussed above should not confront novel issues. If the AIDS infected employee can be shown to present a real danger to the workplace, either because of the danger of AIDS transmission or the danger of opportunistic infection, the grievance of the co-worker should be sustained. If the fear of danger is based upon misconception or can be removed by reasonable accommodation instituted by the employer, the grievance should be denied. While the consideration of opportunistic infections changes the focus of the factual inquiry, it does not change the analysis. In these cases, as the basis for the refusal to work will be federal law, the parties can be expected to invite the arbitrator to consider it in his decision. Consequently, a discussion of decisions under the two arbitral models is unnecessary.

3. DISCHARGE (HEALTH AND SAFETY)

While a seropositive employee's normal workplace activities

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[124] Opportunistic microorganisms (which may be bacteria, fungi, parasites, or viruses) may cause infections exclusively in "compromised hosts" (for example, certain species of Bacillus), or may cause infections more frequently or more severely in compromised than in "normal" hosts. Graevenitz, *Opportunistic Infection,* in Encyclopedia of Science and Technology, Volume 12, 6th Edition. See Appendix J for a more complete discussion of opportunistic infections and their impact on immuno-suppressed individuals.

are unlikely to result the spread of HIV in infection to others,[125] the impact of the developing disease on the infected individual can raise safety issues for the employer. The most conceptually troublesome of these issues is the unknown and, (at least as to the individual worker,) unforeseeable impact of AIDS Dementia Complex, or ADC.

As noted above, the symptoms of ADC can range from minor forgetfulness to severe dementia and psychomotor retardation.[126] The uncertain development of undiagnosed but potentially progressive mental defects has led some to argue that even asymptomatic individuals who are seropositive for the HIV virus should be banned from certain professions in the interests of public safety.[127] This concern for safety would theoretically

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[125] This discussion necessarily excludes the unique problems posed by the health-care environment. However, even there the analysis should be the same; (a) Does the employee's condition present a threat to his co-workers or to clients? (b) Can the threat be eliminated by steps short of discharge? (c) Do the steps necessary to eliminate the threat constitute an unreasonable burden on the workplace? Given the invasive procedures conducted by health care providers, there is a very real danger of worker and client infection. See Appendix K for a list of articles which address this issue.

[126] See Footnotes [33] and [34] and accompanying text above.

[127] "There is thus a well documented medical likelihood that large numbers of those infected with the AIDS virus are subject to central nervous system dysfunction, that the cause of the dysfunction is difficult to detect and often misdiagnosed until it reaches a more serious stage, and that this dysfunction can occur in asymptomatic carriers of the virus entirely independent of any damage to the immune system associated with a diagnosis of AIDS. These findings have an impact on a wide range of employees, infected with the AIDS virus who may not be 'otherwise qualified' because of the risk that they will sustain damage to their central nervous system resulting in varying forms of mental deficiency and brain dysfunction that might place others in danger and prevent them from performing the 'essential functions' of their jobs.

The employees that such a risk would most immediately impact are those whose jobs entail significant responsibility for the safety of others: bus drivers, airline pilots, air traffic controllers, police officers, elevator and fire

support similar restrictions in non-public but inherently dangerous occupations where even mild cognitive disorders might pose a risk of serious injury. However, despite the general concern, there is also scientific authority for the contrary view; that asymptomatic individuals who are seropositive for the HIV virus will not suffer from mental disturbances before suffering from AIDS itself.[128]

Given the conflicting nature of the scientific evidence, the arbitrator should treat a discharge for suspected or anticipated AIDS related dementia in the same way he would treat any other discharge or adverse action involving allegations of mental disease. Traditionally, whether the arbitrator confines himself to the four corners of the contract, (using some version of "just cause" as his standard,) or incorporates external law, the arbitrator's analysis has been centered on the actual condition of the grievant.[129] "Evidence" consisting solely of unsupported

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inspectors, as well as a host of other jobs where an employee's mental deficiency or brain dysfunction could threaten the safety of others. There are many other jobs, which require complex abstracting ability or rapid information processing, where the asymptomatic carrier of the AIDS virus would not be otherwise qualified for employment under the 'business necessity and safe performance' defense provided by the Department of Labor's regulations interpreting section 504 of the Rehabilitation Act." Hentoff, *The Rehabilitation Act's Otherwise Qualified Requirement and the AIDS Virus: Protecting the Public from AIDS-Related Health and Safety Hazards,* 30 Ariz. L. Rev. 571, (1988).

[128] **The World Health Organization,** *Statement on neuropsychological aspects of HIV infection,* **(March 13, 1988) as quoted in** Hentoff, *The Rehabilitation Act's Otherwise Qualified Requirement and the AIDS Virus: Protecting the Public from AIDS-Related Health and Safety Hazards,* 30 Ariz. L. Rev. 571, (1988), **at Footnote [248].**

[129] **For example, consider the opinion of Arbitrator David A. Concepcion in** *SACRAMENTO MUNICIPAL UTILITY DISTRICT,* 91 LAB. ARB. (BNA) 1073, (1988), **where the discharge of a building maintenance sub-foreman was upheld. The employee**

generalizations, made without consideration of the particular condition of the grievant, has been rejected in favor of more particularized proof. If the employer can establish *the grievant* is suffering from a mental defect which prevents him from performing the job for which he was hired, and that reasonable accommodation will not permit the employee to perform that job, the discharge is sustained. A failure of proof as to *the grievant* dictates reinstatement.[130]

There is no reason this mode of analysis should not apply in an AIDS case in the same manner as it does in any other case involving allegations of mental defect. Those who call for presumptive disqualification of HIV positive employees implicitly argue that the HIV-free employee is, by definition, free from physical or mental imbalances. However, none would argue that the employer who ignores such deterioration in any of his

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exhibited erratic behavior, wild mood shifts and used prescription tranquilizer drugs chronically. A psychiatrist diagnosed grievant as "manic depressive with immature personal features" and concluded that his emotional instability "would preclude him from his work at the nuclear power plant." Oddly, the union in this case presented no countervailing expert opinion despite the fact that the diagnosis would prevent grievant from obtaining necessary security clearance. For a case showing reinstatement, see *EAST OHIO GAS CO.*, 91 LAB. ARB. (BNA) 366, (1988). In Ohio Gas, Arbitrator Jonathan Dworkin held the non-disciplinary discharge of employee who could not perform regular duties because of acute anxiety depression was arbitrary. The employer had discharged the grievant based on medical evidence two months old and expert witness testified that anxietydepression patients often respond quickly to treatment. Significantly, this decision was not made under a "just cause" standard but under the more difficult (for the employee,) standard of "reasonable or arbitrary" action under contractual management-rights clause.

[130] The use of generalizations or "group guilt" unrelated to the particular grievant has been rejected as inherently unfair in the discipline area. Hill & Beck, *Some Thoughts on Just Cause and Group Discipline*, 41 Arb.J. 59 (J 1986). The same philosophical rational would seem to apply in the cases involving AIDS related discharges based solely on attenuated medical generalizations.

employees does so at his own peril. If the employer detects forgetfulness, emotional or physical disturbances, or any other "odd" behavior, that behavior should be investigated. Whether the employer determines the unacceptable behavior is due to clinical depression, drug abuse, alcoholism, physical disease or transitory personal problems, the traditional arbitral standard in a discharge case remains how such behavior detracts from the worker's ability to do the job. There seems no reason to forge a new standard for workers who are HIV positive.

4. DISCHARGE (INABILITY TO PERFORM)

What standard should the arbitrator apply if the employer discharges an HIV-positive employee who the employer alleges is no longer able to perform the job for which he was hired? In a published arbitration decision directly on point,[131] Arbitrator Sid Braufman described the standard simply:

> "Whether the grievant suffers from some form of AIDS or from some other disease or illness, should be immaterial so far as his employment status is concerned. What is really crucial, in my view, is whether or not, despite his health problem, the grievant is truly capable of doing his job. If he is, then he should be permitted to return to work promptly provided of course, that such return poses no additional health threat either to the grievant or to his co- workers."

Arbitrator Braufman directed that the discharge be converted to

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[131] *In re The Bucklers, Inc. and Local 517-S, Production, Services and Sales District Council, AFL-CIO*, 90 Lab. Arb. (BNA) 937, NYS Mediation Board Case No. AP 87-918, (1987).

an involuntary unpaid medical leave of absence and ordered the parties to have the grievant examined by a physician who specialized in AIDS. Arbitrator Braufman further ordered the parties to inform the selected AIDS specialist of the regular duties of the grievant's position so he could certify whether the grievant was fit to perform the full range of those duties without jeopardy to himself or his co-workers. Arbitrator Braufman further noted that "if the specialist finds and certifies, however, that the grievant is not fit to perform the full range of his duties, then the grievant shall continue on involuntary medical or disability leave, subject to the terms and conditions of the pertinent provisions of the labor agreement and/or the customary practice of the parties."

The standard enunciated by Arbitrator Braufman faithfully tracks the standard used by other arbitrators in non-AIDS related discharge cases. Employers who wish to discharge or take other adverse action against an employee[132] bear the burden of establishing that employee cannot perform the job for which he

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[132] For similar analysis in a reassignment case, see *IN RE HAMILTON COUNTY SHERIFF*, 90 Lab.Arb. (BNA) 1012, FMCS Case No. 88-0808 (1988), An exemplary seven-year road-patrol officer with medically controlled seizure disorder was reassigned to clerk duties following on-duty seizure. Arbitrator Lawrence R. Loeb rejected as "arbitrary" a county demand for a medical guarantee against future seizures. Key factors were the county's knowledge of disorder at time of hire, the fact that the officer's condition had not deteriorated during employment, and, most importantly, the fact that three physicians, including one chosen by county, determined the grievant was medically fit to perform all patrol-officer duties.

was hired.[133] Arbitrators require the employer to establish the grievant's disability by recent medical examination which considers the requirements of the grievant's job.[134]

Will recourse to external law result in a different decision than that rendered by a arbitrator who confines himself to the four corners of the collective bargaining agreement? In this area the answer may be yes. As noted above, both the Rehabilitation Act of 1973 and the recently passed Americans With Disabilities Act require the employer to make "reasonable accommodation" for the grievant's disability.[135] What constitutes reasonable accommodation will be determined by a factual inquiry in each case. However, it is at least clear from the cases that the employer is not required to assign the employee to a new job or fundamentally change the work process to

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[133] See: *CITY OF ITHACA*, 94 Lab. Arb. (BNA) 747, PERB Case No. A89-186, (1990,) where Arbitrator Mona Miller found the city sanitation department improperly discharged garbage collector who had 50-pound lifting restriction, despite contention that it had fulfilled duty to accommodate grievant by assigning him temporarily to recycling job until disability was determined to be permanent. Arbitrator Miller rejected the city's position that permanent assignment to the recycling job would mean creation of a new position, specifically finding that the garbage collection and recycling jobs were intermingled. As grievant was qualified and able to perform all functions of the related (substantially equivalent) recycling job, his discharge was improper and *EAST OHIO GAS CO.*, 91 LAB. ARB. (BNA) 366, (1988), described in Footnote [129] above.

[134] See: *PACIFIC BELL*, 91 Lab. Arb. (BNA) 653 (1988) and *WEYERHAEUSER COMPANY*, 88 Lab. Arb. (BNA) 270, (1987) discussed at Footnote [109] above.

[135] See Footnote [79] and accompanying text above.

design a job the grievant can do.[136] An arbitrator who incorporates federal law may require the employer to take specific steps before a discharge will be upheld,[137] steps not required under the strict language of the collective bargaining agreement.

Whether a decision under the "four corners" model will be reversed as a violation of state or federal handicapped statutes will depend entirely upon whether the collective bargaining agreement is interpreted in a manner which is consistent with the principles embodied in such statutes. Even if the precise statutory language is absent from the collective bargaining agreement, "reasonable accommodation" as described by federal and state law could be reached by an arbitrator using a traditional

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[136] See for example: *LAMOTT v. APPLE VALLEY HEALTH CARE CENTER, INC.*, --- N.W.2d ----, 1991 WL 6476 (Minn.App.)(Nursing Home failed to reasonably accommodate victim of cerebral hemorrhage when it assigned her to new duties with which she was unfamiliar and gave her no guidance.); *COFFMAN V. WEST VIRGINIA BD. OF REGENTS*, 386 S.E.2d 1, 52 Empl. Prac. Dec. P 39,731, 57 Ed.Law Rep. 277, (A decision under the West Virginia human rights statute where the court held the law did not require the employer to assign a custodian to different job he could perform); *RANCOUR V. DETROIT EDISON CO.*, 388 N.W.2d 336, 150 Mich.App. 276, 47 Fair Empl.Prac.Cas. (BNA) 1284, (A decision under Michigan handicap law holding the employer is not required to place an injured employee who cannot perform original job into new job).

[137] See: *In re DEPARTMENT OF HEALTH AND HUMAN SERVICES, SOCIAL SECURITY ADMINISTRATION*, 87 Lab. Arb. (BNA) 1026, FMCS NO. 86 K 00876, (1986) where Arbitrator Aaron S. Wolff Employer held the agency improperly discharged an employee for poor performance several months after he returned to work from approved absence for hospitalization and treatment of alcoholism. Critical to the arbitrator's decision was the employer's failure to conduct a formal evaluation, including the "fitness for duty" examination required by law and contract, to determine whether employee's continued under-performance was attributable to alcoholism, to anxiety and depression-producing "white knuckle sobriety" experienced by some recovering alcoholics, or to some other health problem. Also noted was the agency's obligation, under the law, regulation and other mandates to act as a 'model employer' (29 CFR 1613.703) and to make reasonable accommodations to the grievant's disease and handicap (29 CFR 1613.704). Failure to do so constituted prohibited discrimination.

interpretation of the "just cause" provision contained in that agreement. This would insulate the arbitrator's decision from reversal on public policy grounds while eliminating the need to expressly invoke external law. However, unless the arbitrator's use of the statutory standard is accidental, the his "discovery" of the proper interpretation of the just cause provision seems to be merely a thinly disguised incorporation of external law. If this is what an arbitrator must do to produce an enforceable in this regulated environment, does he or she have an affirmative duty to tell the parties that they have a contractual problem which they must address at the bargaining table?

The Americans with Disabilities Act's focus on individual rights and its enforcement mechanisms mirror those of Title VII. If awards which violate a grievant's rights face almost certain reversal on public policy grounds, will this new, pervasive regulation force traditionalists within the arbitration community to specifically incorporate external law when dealing with AIDS and other disability related grievances? Again, the short answer seems to be no. First, the base standards in the new law have been part of many workplaces for almost two decades under the terms of the Vocational Rehabilitation Act of 1973. Secondly, the new Act's restrictions will take time to absorb, there is no reason to believe they will not ultimately become part of the "law of the shop" in much the same way as EEO restrictions and principals have during the past two decades. To

the extent the parties wish to take more rapid steps to ensure subsequent awards embody these principals, they are free to do so when they draft their collective bargaining agreement or set the limits of their arbitrator's jurisdiction.

Under either model, the fact that the grievant suffers from AIDS (vice another disability,) does not appear to trigger additional decisional factors. The arbitrator should therefore decide these cases by reference to traditional principles developed in the context of other disability related discharges.

5. TESTING

The concerns about AIDS have prompted some employers to implement testing programs under the management rights provisions of the collective bargaining agreement.[138] The justification for the imposition of such testing policies is generally a rough identification of the nature of Acquired Immune Deficiency Syndrome, (a communicable disease,) coupled with the consequences of infection, (invariably death.) As noted above, this analysis ignores the overwhelming opinion of the worldwide scientific

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[138] See: *STERLING MORTON HIGH SCHOOL*, 89 Lab. Arb. (BNA) 521, (1987) Where Arbitrator Fred Witney held the School Board's adoption of testing policy permitting school board to require employees whom it reasonably suspects of having "highly contagious disease" to be examined by board-appointed physician and/ or to take sick or health leave violated the collective bargaining contract and Illinois law. The arbitrator specifically found the policy was enacted solely in response to the AIDS epidemic and was based on the "unsupported assumption" that AIDS is highly contagious and represents a "clear and present danger" within the school setting.

community concerning the nature of the threat of infection due to casual contact.[139]

Arbitrators faced with discharges resulting from employee refusals to comply with employer demands for medical testing have applied a rather simple test. If the employer cannot articulate a rational reason for the original demand which brings it within the terms of the collective bargaining agreement, the employee is reinstated.[140]. Employer demands for AIDS testing would clearly be subject to this same, traditional, standard.

Unless the employer can establish a legitimate, work-related reason to test his employees, the imposition of such a program as well as the discharge of employees who refuse to comply, should be overturned. Given the scientific facts concerning AIDS, it is unclear what that work-related reason could be in the average

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[139] See Footnotes [27] through [29] and accompanying text above.

[140] See, *LACLEDE GAS CO.*, 89 Lab. Arb. (BNA) 398, (1987), where Arbitrator John J. Mikrut Jr. reinstated an employee who refused to retake drug test after he had tested positive for marijuana, where he had completed employee assistance program and was subject to random drug-screening pursuant to company procedure for qualifying truck drivers under federal regulations. Just cause did not exist to discharge employee where the employer's procedure did not address discipline for refusal to take test. and *GULF ATLANTIC DISTRIBUTION SVCS.*, 88 Lab. Arb. (BNA) 475, FMCS Case No. 86K/07146, (1986), where Arbitrator J. Earl Williams found that just cause did not exist for "insubordination" discharge of employee who refused to submit to physical examination ordered after two polygraph tests, to which employee had voluntarily submitted in employer's investigation of missing merchandise, allegedly showed marked physiological changes. Key factors for the arbitrator were the fact the order was not directly related to the grievant's job, that there was no substantial evidence that employee might have injurious disease or that he was incapable of performing job without endangering himself and/or others.

work place.[141] In the typical case, an adherence to traditional standards would dictate reinstatement for the employee who was discharged for refusing to take an AIDS test.

6. REFUSAL TO PROMOTE

What should an arbitrator do in a case where the grievant has been denied a promotion based upon his or her AIDS related condition? Assume an HIV positive grievant has been denied advancement on the basis of his condition. The hypothetical employer asserts that the position applied for requires extensive training and would place the grievant in charge of long term projects. The employer doesn't want to "waste" the training on a presumptively terminal employee and wants to select an applicant who will "be around" to supervise the conclusion of his or her long-term commitments. The employer argues that, due to HIV infection, the grievant is an extremely poor risk on both counts. What should be the arbitrator's decision?

First, the arbitrator should determine whether the HIV positive grievant is physically capable of performing the duties of the desired position now. In the case of a seropositive but asymptomatic grievant the answer should be yes. If the

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[141] While there seems little justification for AIDS related testing in the normal work environment, there may be justification for such testing in some settings. See Appendix K for a list of articles which discuss the need for AIDS related information in the health care environment.

grievant's condition has progressed to AIDS Related Complex (ARC) or if the grievant is suffering from "full blown" AIDS, the answer may be no. There is no new "AIDS" analysis needed at this stage. The employer should be required to list the physical (place, time and duty) requirements of the job and establish why the grievant cannot fulfill those requirements. If the grievant can't, with reasonable accommodation, perform the duties now, the arbitrator should resolve the grievance in the employer's favor.

The employer's objections however are related to suppositions concerning the grievant's expected future capabilities, not his present performance. The question confronting the arbitrator is whether to uphold an adverse action based on such employer predictions. In most cases the answer should be no.

As noted above,[142] there is currently no way to predict how long it will take a seropositive grievant to develop ARC or AIDS, or even whether he or she will develop those conditions. Such an employee is no more "likely" to die in the foreseeable future than any other employee. A grievant who has developed ARC will experience minor health problems, but may not develop AIDS. There is simply no way to predict the course of the ARC grievant's condition or whether the ailments associated with ARC will materially interfere with his or her ability to perform.

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[142] **See Footnotes [36] through [41] and accompanying text above.**

Given the facts espoused by medical authorities, the hypothetical employer's belief in the grievant's impending demise does not appear to be particularly well founded.

The average arbitrator would not sustain the actions of an employer who refused to promote men after they reach fifty (because they have an increased risk of heart attack) or discriminated against married women of child bearing age (because they might become pregnant.) The same sort of analysis should be applied in most AIDS cases. The arbitrator should look to the employer for proof that the grievant will not be able to fulfill the requirements of the job. Absent such proof, the grievant should prevail.[143]

The discussion above may not apply to people who have developed AIDS itself. People with full AIDS symptoms often experience bouts of extreme illness and will probably require considerable accommodation from their employers to perform their normal duties. As the life expectancy of these patients is between eighteen months to two years, the employer's decision to

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[143] See *In re Hamilton County Sheriff and Fraternal Order of Police*, 90 Lab.Arb. (BNA) 1012 (1988) where Arbitrator Lawrence Loeb found the employer had improperly reassigned a police officer to clerk duties after medical treatment related to his epilepsy. (The employer had ignored medical evidence that the grievant's condition was medically controlled and had demanded a "guarantee" against future seizures.) For comparison, see the decisions in the following cases where adverse employment actions involving "disabled" applicants were found to violate state discrimination laws: *Dairy Equipment Co. v. Dept. of Industry, Labor and Human Relations*, 15 Empl.Prac.Dec. P 8052, (only one functioning kidney); *Chrysler Outboard Corp. v. Dept. of Industry, Labor and Human Relations*, 14 FEP Cases 344, (acute lymphocytic leukemia in remission); *Fraser Shipyards, Inc. v. Dept. of Industry, Labor and Human Relations*, (diabetes).

exclude such a person from a lengthy or demanding training program could be justified. The analysis however is unchanged. The arbitrator should still require the employer to present sufficient medical evidence to establish the grievant should be excluded from consideration for promotion or training. In the cases of a grievant suffering from "full blown" AIDS, the evidence indicates such decisions may very well go to the employer.

G. CONCLUSION

Despite the political and social undercurrents which continue to characterize discussions of Acquired Immune Deficiency Syndrome, an examination of the facts now available suggests that these should not be difficult cases for arbitrators. Certainly the social issues discussed are relevant to the arbitrator faced with an AIDS related controversy as they will be to the parties whose perceptions of these issues will shape the dispute. However, the arbitrator who desires to reach a decision based upon the facts rather than the conflicting fears of the parties needs to come to the hearing with a clear understanding of the real issues.

There is no evidence Acquired Immune Deficiency Syndrome can be transmitted by casual contact. This renders the infection of an employee factually irrelevant to others with whom he has such

contact. Under the circumstances, the traditional principles applied by arbitrators in cases involving less emotionally charged physical disabilities can and should be applied by arbitrators in cases involving AIDS.

Arbitrators should recognize that there are both federal and state laws which restrict employer discretion in the hiring and firing of persons classified as "disabled". Infectious diseases such as AIDS have been found to constitute disabilities under those laws. An arbitration decision which concerns a discharge or other adverse action against an HIV-infected employee will likely fall within the parameters of these restrictions.

An arbitrator who follows the traditional "four corners" model, needs to recognize that decisions involving AIDS related disputes, like all decisions involving disabilities, are issued within an increasingly regulated environment. These laws expand the possibility of later courtroom challenges on public policy grounds. Under the circumstances, parties seeking to avoid further litigation ought to consider requesting the incorporation of external discrimination law, (if only to make it clear that the principles embodied in such laws were honored.)

The arbitrator who regularly incorporates external law in his or her decisions should become familiar with the state and federal statutes which will govern the dispute if it moves from

the arbitration hearing room to the courts. A clear enunciation of the factors and standards established by those laws should insure the arbitration decision results in an enforceable award which reflects an accurate view of the facts.

APPENDIX A

AIDS cases reported to the CDC--United States, cumulative totals.

June 1981-May 1988

Adults/Adolescents		
Transmission categories	Number	Percent
Homosexual/bisexual male	37,999	63%
Homosexual male and IV drug abuser	4,438	7
Heterosexual IV drug abuser	11,045	18
Heterosexual cases	2,463	4
Undetermined	1,894	3
Transfusion recipients	1,467	2
Hemophilia and coagulation disorders	591	1
TOTALS	59,897	100%

Children (birth to 13)		
Transmission categories	Number	Percent
Parent with AIDS or at risk for AIDS	735	77%
Transfusion recipients	131	14
Hemophilia and coagulation disorders	53	6
Undetermined	36	4
TOTALS	955	100

COMBINED TOTALS	60,842

Margolis, The AIDS Epidemic: Reality Versus Myth, 72 Judicature 58, (1988)

APPENDIX B

Consider the tone and content of the following comments delivered on the floor the 101st United States Congress, Second Session on Thursday, May 3, 1990:

The SPEAKER pro tempore.

"Under a previous order of the House, the gentleman from California <Mr. DORNAN> is recognized for 60 minutes."

Mr. DORNAN of California.

"Mr. Speaker, with this early adjournment of the House, just barely after 1 o'clock, only 10:05 in California time, 8:05, early morning in Hawaii and Alaska, I wanted to take this opportunity to cover several subjects. I was unable to address these subjects in the very brief and exciting 1-minute speeches that serve as a steam pressure valve for a lot of our feelings here in the House. We restricted them the other morning, so I am going to take the opportunity here in these very rare special orders to cover several subjects that have been burning inside of me, frankly, the last month. So I want to share them with you, and through you to the American people...These homosexuals activists were told by an NIH doctor that the best hope for a cure for them is using live fetal tissue, tissue taken from babies extracted from their mothers' wombs before they are killed, or allowed to die. They can use this tissue and maybe cure AIDS.

Imagine telling people on the verge of a ghastly death where they will shrivel up into their prenatal position, their body covered with every type of opportunistic cancer, particularly Kaposi's sarcoma, big black open sores, where they will get dementia attacks upon their brain, heart failure, lung attacks, pulmonary problems galore. Imagine telling these people, "The cure for you if you are HIV-positive, that is if you have already been infected with the disease but it has not manifested itself yet, or if you are an early ARC or if you are early dementia manifestation type, you feel yourself losing your memory or you are starting to lose body weight for no explicable reason, what they call the thinning disease in Africa when AIDS first manifested itself. Imagine somebody telling you that the way to save yourself is "to become active in the abortion movement, kill more babies, get more of those fetuses and use them in medical research, and it will extend your life.

So as a way to justify sodomy or whatever life style, high-risk group, that is the way the medical profession calls it, whatever got you into this mess, the way to get out of it is to get fetuses and use this living tissue to try to extend the life that you have foreshortened by your personal conduct.

Even to tell it to people who are innocent victims like little Ryan White, who just died, who got it through blood transfusions, either for medical reasons, an accident, something like hemophilia is unconscionable."

1990 WL 56674 (Cong.Rec.) 136 Cong.Rec. H2029-01

APPENDIX C

IN THE UNITED STATES, PEOPLE OF COLOR MAKE UP A DISPROPORTIONATE NUMBER OF PERSONS WITH AIDS:	
People with AIDS in the U.S. who are minorities:	37%
Women with AIDS who are women of color,	87%
Heterosexually infected persons who are black or hispanic women	(MOST)
Children with AIDS who are non-white,	91%
Person with AIDS in Newark, N.J., who are heterosexual black people.	60%
Persons with AIDS in Washington, D.C., who are non-white heterosexuals.	50%
Persons with AIDS in New York City who are heterosexuals % of these which are black or hispanic	50% 80%

Harrington, *A Fatal Bias: AIDS and Minorities,* 14 Hum.Rts. 34 (1987) (Published by the Section of Individual Rights and Responsibilities, American Bar Association.)

APPENDIX D

Diffuse pneumonitis is a common manifestation of AIDS. AIDS patients frequently develop cough, shortness of breath, and fever, symptoms that can develop acutely over several days or insidiously over weeks or months. Pneumocystis pneumonia in AIDS patients is characterized by a subacute and insidious onset as the patient complains of a mild cough or chest discomfort of 2-10 weeks' duration. Unlike other groups of immunosuppressed patients, AIDS patients suffer frequent relapses of pneumocystis pneumonia.

Inflammation of the choroid and retina is also common in AIDS patients. Although occasional AIDS patients are seen with Toxoplasma retinitis, the most common cause of progressive chorioretinitis is cytomegalovirus. Initially patients are asymptomatic, but later, vision becomes compromised.

Persistent or recurrent diarrhea that can reach 4 gallons (15 liters) per day is another frequent problem among AIDS patients. Homosexuals with AIDS may have a range of bowel complaints due to the enteric organisms that cause symptomatic disease in the general gay population, including Entamoeba histolytica, Giardia lamblia, and Shigella, Salmonella, and Campylobacter species. Appropriate antimicrobial therapy that eliminates these pathogens often fails to eliminate the copious watery diarrhea. Some patients with persistent watery stools have cryptosporidiosis, a major untreatable problem for AIDS patients. Many AIDS patients with persistent diarrhea have no demonstrable pathogen despite careful stool examination, endoscopy, small bowel biopsy, and autopsy."

Macher, Acquired Immune Deficiency Syndrome, Encyclopedia of Science and Technology, Volume 1, 6th Edition.

APPENDIX E

Wilson, *Chalk v. United States District Court Central District: Quick Remediation for AIDS Victims Who Cannot Afford to Wait, Note*, 26 Hous. L. Rev. 1033, (1989)

Solin and McLanahan, *18TH Annual Institute on Employment Law Workplace Claims*, Prac.Law Inst. Order No. H4-5070, (1989)

Tschirn, *AIDS as a Protected Handicap Under the Civil Rights Restoration Act of 1987*, 35 Loy. L. Rev. 243, (1989)

Colker, *Administrative Prosecutorial Indiscretion*, 63 Tul.L.Rev. 877, (1989) (A general discussion of prosecutorial discretion as it pertains to the enforcement of anti-discrimination statutes)

Leonard, *AIDS, Employment and Unemployment*, 49 Ohio St.L.J. 929, (1989)

Baxley, *Rehabilitating AIDS-based Employment Discrimination: HIV Infection as a Handicap Under the Vocational Rehabilitation Act of 1973*, 19 Seton Hall L.Rev. 23, (1989)

Gerry, *Section 504 of the Rehabilitation Act, HIV and AIDS: Legal Implications*, 4 Issues L. And Med. 175, (1988)

Michael, *Chalk v. United States District Court Central District of California: A Major Victory for AIDS Employees Under the Federal Rehabilitation Act of 1973*, 22 Akron L.Rev. 241, (1988)

Gentemann, *After School Board of Nassau County v. Arline: Employees with AIDS and the Concerns of the 'Worried Well'*, 37 Am.U.L.Rev. 867, (1988)

Lipshutz, *Arline: Real Protection Against Discrimination for Society's New Out Casts? School Bd. of Nassau County v. Arline, 107 S. Ct. 1123 (1987)*, XVII Stetson L.Rev. 517 (1988)

Appebaum, *The Application of Handicap Discrimination Laws to AIDS Patients*, 22 U.S.F.L.Rev. 317, (1988)

Lally-Green, *Is AIDS a Handicap Under the Rehabilitation Act of 1973 After School Board v. Arline and the Civil Rights Restoration Act of 1987?*, 19 U.Tol.L.Rev. 603 (1988)

Brooks, *School Board v. Arline: Will AIDS Fit the Mold?*, 41 Ark.L.Rev. 639, (1988)

O'Conner, *Defining 'Handicap' for Purposes of Employment Discrimination*, 30 Ariz.L.Rev. 633, (1988)

Hentoff, *The Rehabilitation Act's otherwise Qualified Requirement and the AIDS Virus: Protecting the Public From Aids-Related Health and Safety Hazards*, 30 Ariz. L. Rev. 571, (1988)

Horn, *Protecting Persons With AIDS From Employment Discrimination*, 77 Ky.L.J. 403, (1988-89)

Minow, *Foreword: Justice Engendered*, 101 Harv.L.Rev. 10, (1987)

Landolt, *Are AIDS Victims Handicapped?*, 31 St. Louis L.J. 729, (1987)

Anderson, *Employment Discrimination: Tuberculosis is a Handicap Within the Meaning of Section 504 of the Rehabilitation Act of 1973 [School Board v. Arline, 107 S.CT. 1123 (1987)]*, 27 Washburn L.J. 207, (1987)

Carey, *16th Annual Institute on Employment Law: Concern in the Workplace, Recent Developments on the Rights of the Handicapped, Disabled or Injured Worker*, Prac.Law Inst. Order No. H4-5020, 327 PLI/Lit 283, (1987)

Wasson, *AIDS Discrimination Under Federal, State, and Local Law After Arline*, 15 Fla. St. U.L. Rev. 221, (1987)

Loomis, *16th Annual Institute on Employment Law: Concern in the Workplace Handicap Discrimination: Alcohol, Drugs, and AIDS*, Prac.Law Inst. Order No. H4-5020, 327 PLI/Lit 389, (1987)

Curylo, *AIDS and Employment Discrimination: Should AIDS be Considered a Handicap?*, 33 Wayne L. Rev. 1095, (1987)

Hilton, *Civil Rights--Rehabilitation Act of 1973--Individual Affected With Contagious Disease Held 'Handicapped' and Entitled to Protection of Section 504 (29 U.S.C. S 794). School Board of Nassau County v. Arline, ___ U.S. ___, 107 S. CT. 1123, 94 L. ED. 2D 307 (1987)*, 19 St. Mary's L.J. 231, (1987)

Pabst, *Protection of AIDS Victims From Employment Discrimination Under the Rehabilitation Act*, 1987 U.Ill.L.Rev. 355

Kube, *AIDS and Employment Discrimination Under the Federal Rehabilitation Act of 1973 and Virginia's Rights of Persons With Disabilities Act*, 20 U. Rich L. Rev. 425, (1986)

Mitchell, *Employment Discrimination and AIDS: is AIDS a Handicap Under Section 504 of the Rehabilitation Act?*, XXXVIII U. Fla. L. Rev. 649, (1986)

Carey and Laws, *15th Annual Institute on Employment Law Handicap Discrimination and Special Employee Health Problems*, Prac.Law Inst. Order No. H4-4997, 308 PLI/Lit 135, (1986)

Freedman, *Wrong Without Remedy*, 72 A.B.A.J. 36, (1986)

APPENDIX F

AIDS PROTECTION UNDER STATE CIVIL RIGHTS LAWS (1990)

No state civil rights laws	5
State Civil Rights laws which exclude AIDS and HIV related disease from communicable disease coverage	4
State Civil Rights law but no rulings or other indications whether AIDS suffers are "handicapped within the meaning of the Act	8
State Civil Rights law with indications from state enforcement agency that AIDS suffers are "handicapped within the meaning of the Act (No cases law or formal rulings)	17*
State Civil Rights law with either positive language or case law which establish that AIDS suffers are "handicapped within the meaning of the Act	15
State law which is inconsistent (Explicit prohibition of discrimination based on HIV infection but exceptions which arguably permit discrimination in hiring and testing.)	1

* Seventeen states and the District of Columbia

Epidemic of Fear, A Guide to the Legal Problems of People With AIDS, **Published by the LAMBDA Legal Defense Fund. (1990)**

APPENDIX G

AMERICANS WITH DISABILITIES ACT OF 1990 (104 Stat 327, 331-332)

SEC. 101. DEFINITIONS.

(9) REASONABLE ACCOMMODATION - The term "reasonable accommodation" may include:

(A) making existing facilities used by employees readily accessible to and usable by individuals with disabilities; and

(B) job restructuring, part-time or modified work schedules, reassignment to a vacant position, acquisition or modification of equipment or devices, appropriate adjustment or modifications of examinations, training materials or policies, the provision of qualified readers or interpreters, and other similar accommodations for individuals with disabilities.

(10) UNDUE HARDSHIP -

(A) IN GENERAL - The term "undue hardship" means an action requiring significant difficulty or expense, when considered in light of the factors set forth in subparagraph (B).

(B) FACTORS TO BE CONSIDERED - In determining whether an accommodation would impose an undue hardship on a covered entity, factors to be considered include:

(i) the nature and cost of the accommodation needed under this Act;

(ii) the overall financial resources of the facility or facilities involved in the provision of the reasonable accommodation; the number of persons employed at such facility; the effect on expenses and resources, or the impact otherwise of such accommodation upon the operation of the facility;

(iii) the overall financial resources of the covered entity; the overall size of the business of a covered entity with respect to the number of its employees; the number, type, and location of its facilities; and

(iv) the type of operation or operations of the covered entity, including the composition, structure, and functions of the work force of such entity; the geographic separateness, administrative, or fiscal relationship of the facility or facilities in question to the covered entity.

AMERICANS WITH DISABILITIES ACT OF 1990 (104 Stat 327, 331-332)

§102. DISCRIMINATION

(b) CONSTRUCTION.--As used in subsection (a), the term "discriminate" includes--

(1) limiting, segregating, or classifying a job applicant or employee in a way that adversely affects the opportunities or status of such applicant or employee because of the disability of such applicant or employee;

(2) participating in a contractual or other arrangement or relationship that has the effect of subjecting a covered entity's qualified applicant or employee with a disability to the discrimination prohibited by this title (such relationship includes a relationship with an employment or referral agency, labor union, an organization providing fringe benefits to an employee of the covered entity, or an organization providing training and apprenticeship programs);

(3) utilizing standards, criteria, or methods of administration--

(A) that have the effect of discrimination on the basis of disability; or

(B) that perpetuate the discrimination of others who are subject to common administrative control;

(4) excluding or otherwise denying equal jobs or benefits to a qualified individual because of the known disability of an individual with whom the qualified individual is known to have a relationship or association;

(5) (A) not making reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, unless such covered entity can demonstrate that the accommodation would impose an undue hardship on the operation of the business of such covered entity; or

(B) denying employment opportunities to a job applicant or employee who is an otherwise qualified individual with a disability, if such denial is based on the need of such covered entity to make reasonable accommodation to the physical or mental impairments of the employee or applicant;

(6) using qualification standards, employment tests or other selection criteria that screen out or tend to screen out an individual with a disability or a class of individuals with disabilities unless the standard, test or other selection criteria, as used by the covered entity, is shown to be job-related for the position in question and is consistent with business necessity; and

(7) failing to select and administer tests concerning employment in the most effective manner to ensure that, when such test is administered to a job applicant or employee who has a disability that impairs sensory, manual, or speaking skills, such test results accurately reflect the skills, aptitude, or whatever other factor of such applicant or employee that such test purports to measure, rather than reflecting the impaired sensory, manual, or speaking skills of such employee or applicant (except where such skills are the factors that the test purports to measure).

APPENDIX H
ARBITRATION OF ABSENTEEISM CASES 1975-1981[1]

CASE OUTCOME AS IT RELATES TO REASON FOR DISCHARGE

Reason for Discharge	Discharge Upheld	Employee Reinstated	Split Decision	Total Cases
Failure to Call in	18 (58.6%)	5 (17.2%)	7 (24.1%)	30 (20.5%)
Failure to Follow Procedures	3 (60.0%)	2 (40.0%)	0 (NA)	5 (3.4%)
Insubordination (Refusal to Come to Work)	1 (25.0%)	2 (50.0%)	1 (25.0%)	4 (2.7%)
Dishonesty (Lying about Reason for Absence)	2 (28.6%)	1 (14.3%)	4 (57.1%)	7 (4.8%)
Identifiable Pattern of Absences	2 (100.0%)	0 (NA)	0 (NA)	2 (1.4%)
Incarceration	3 (100.0%)	0 (NA)	0 (NA)	3 (2.1%)
Excessive Absenteeism	42 (53.9%)	16 (20.5%)	20 (25.6%)	78 (53.4%)
Irresponsible and Unreliable	1 (50.0%)	1 (50.0%)	0 (NA)	2 (1.4%)
Failure to Report to Work	5 (38.5%)	2 (15.4%)	6 (46.2%)	13 (8.9%)
Other	0 (NA)	1 (50.0%)	1 (50.0%)	2 (1.4%)
TOTALS	77 (52.7%)	30 (20.5%)	39 (26.8%)	146 (100.0%)

[1] **Scott and Taylor,** *An Analysis of Absenteeism Cases Taken to Arbitration,* **38 Arb.J. 61 (S 983)**

APPENDIX H (Continued)
ARBITRATION OF ABSENTEEISM CASES 1975-1981[1]

CASE OUTCOME AS RELATED TO PROCEDURAL FACTORS

Factors	Discharge Upheld	Employee Reinstated	Split Decision	Total Cases
Established Attendance Policy	70 (55.6%)	26 (20.6%)	30 (23.8%)	126
No Definite Policy	7 (35.0%)	3 (5.0%)	10 (50.0%)	20
Consistent Policy Application	75 (74.3%)	10 (9.9%)	16 (15.8%)	101
No Consistent Policy Application	2 (4.4%)	20 (44.4%)	23 (51.2%)	45
Rules Clearly Communicated	73 (61.3%)	18 (15.1%)	28 (23.5%)	119
Without Employee Knowledge	4 (14.8%)	12 (44.4%)	11 (40.8%)	27
No Company Violation of Policy	75 (73.5%)	10 (9.8%)	17 (16.7%)	102
Company Violates Policy	0 (NA)	20 (48.8%)	21 (51.2%)	41
Had Progressive Discipline	56 (60.9%)	15 (16.3%)	21 (22.8%)	92
Without Progressive Discipline	21 (38.9%)	15 (27.8%)	18 (33.3%)	54
Impartial Investigation	19 (79.2%)	2 (8.3%)	3 (12.5%)	24
Without Impartial Investigation	2 (6.9%)	12 (12.4%)	15 (51.7%)	29
Had Improvement Factor	30 (53.8%)	9 (16.1%)	17 (30.4%)	56
Without Improvement Factor	0 (NA)	1 (33.3%)	2 (66.7%)	3

[1] **Scott and Taylor,** *An Analysis of Absenteeism Cases Taken to Arbitration,* **38 Arb.J. 61 (S 1983)**

APPENDIX I

GRIEVANCE OUTCOMES IN HEALTH AND SAFETY CASES

TYPE OF CASE	TOTAL NUMBER OF CASES[1]	GRIEVANCES UPHELD	GRIEVANCES DENIED/UPHELD IN PART[2]	GRIEVANCES DENIED
Refusal to work for reasons of health and safety	158 (154)	55	32	67
Safety Rule	196 (191)	44	30	117
Crew Size Reduction	65 (62)	11	4	47
Disease and Disability	61 (58)	6	13	39
Performed work but protested working conditions	104 (99)	25	14	60
Total Cases examined	584 (564)	141	93	330

[1] The total of each outcome column is less than the total number of cases found in each ategory due to the circumstances such as insufficient information in the published cases and etention of jurisdiction by an arbitrator which prevented a determination of outcome in a few ases in each category. The number in parentheses indicates the number of cases in which we ould determine a specific outcome.

[2] For refusal to work cases, this column represents any modification of the original enalty. For the other types of cases, this column represents split decisions involving two r more grievants, outcomes to be based on future acts, special circumstances, or additional nformation to be provided to the arbitrator.

Gross and GreenField, *ARBITRAL VALUE JUDGEMENTS IN HEALTH AND SAFETY DISPUTES, MANAGEMENT IGHTS OVER WORKERS' RIGHTS*, 34 Buffalo L.Rev. 645 (1985) (Appendix)

APPENDIX I (Continued)

STANDARD OF PROOF IN REFUSAL TO WORK CASES

TYPE OF CASE	OBJECTIVE PROOF	OBJECTIVE PROOF TERMED REASONABLE BELIEF	REASONABLE BELIEF	GOOD FAITH BELIEF	TOTAL[1]
Refusal to work for reasons of health and safety	50	30	29	11	120

[1] In the remainder of the refusal to work cases, no standard of proof was discussed or could be determined with confidence.

STANDARD OF PROOF AND OUTCOME IN REFUSAL TO WORK CASES

TYPE OF CASE	TOTAL NUMBER OF CASES[1]	GRIEVANCES UPHELD	GRIEVANCES DENIED/UPHELD IN PART	GRIEVANCES DENIED
Objective Proof	50	11	6	33
Objective Proof Termed Reasonable Belief	30	15	9	6
Reasonable Belief	29	16	5	8
Good Faith Belief	11	4	5	2
Unknown	34	9	7	18
Total	154	55	32	67

[1] In the remainder of the refusal to work cases, no standard of proof was discussed or could be determined with confidence.

Gross and GreenField, *ARBITRAL VALUE JUDGEMENTS IN HEALTH AND SAFETY DISPUTES, MANAGEMENT RIGHTS OVER WORKERS' RIGHTS*, 34 Buffalo L.Rev. 645 (1985) (Appendix)

APPENDIX I (Continued)

STANDARD OF PROOF IN REFUSAL TO WORK CASES IN FIVE YEAR INTERVALS

YEARS	TOTAL NUMBER OF CASES	OBJECTIVE PROOF	OBJECTIVE PROOF TERMED REASONABLE BELIEF	REASONABLE BELIEF	GOOD FAITH BELIEF	NO INFO
1945-50	15	5	6	0	0	4
1951-55	13	5	2	1	1	4
1956-60	13	5	2	1	2	3
1961-65	19	4	4	5	2	4
1966-70	36	13	7	7	3	6
1971-75	24	7	4	5	2	6
1976-80	28	10	5	4	1	8
1981-84	10	1	0	6	0	3
TOTALS	158	50	30	29	11	38

Gross and GreenField, *ARBITRAL VALUE JUDGEMENTS IN HEALTH AND SAFETY DISPUTES, MANAGEMENT IGHTS OVER WORKERS' RIGHTS,* **34 Buffalo L.Rev. 645 (1985) (Appendix)**

APPENDIX J

OPPORTUNISTIC INFECTIONS

Infections that owe their emergence to generalized or local defects in the host's defense mechanisms. In general, chances for acquiring an infection in humans are proportionate to the number of microbes at the site of infection, proportionate to their virulence, and inversely proportionate to the strength of the host's defenses. In the years since 1970 opportunistic infections have increased in importance, since patients with such defects can now be kept alive much longer than previously due to various therapeutic measures such as antimicrobial or cancer chemotherapy, surgery, and transplantation.

One possible classification of defects in the host's defense mechanisms would list: defects in the production of antibodies; defects in cell-mediated immunity; defects in phagocytosis; and defects in certain local defense factors. Few human diseases are associated with only one such defect, for example, hypogammaglobulinemia (a defect in antibody production). In most diseases underlying opportunistic infection, multiple mechanisms are at work to affect host defenses. One form of immunosuppression, for instance, is treatment with steroid hormones; it affects cell-mediated immunity, phagocytosis, and (to a lesser degree) antibody production. Another form of immunosuppression, cytotoxic chemotherapy, causes the number of phagocytes to drop, diminishes antibody production, and causes damage to mucous membranes. Under immunosuppressive treatment, there is a high risk of developing opportunistic infections.

Among other conditions favoring opportunistic infections are burns, alcoholism, chronic lung diseases, chronic heart failure, cirrhosis of the liver, renal failure, cystic fibrosis, diabetes mellitus, hypoparathyroidism, sickle-cell disease, leukemias, lymphomas, and various defects in phagocytic mechanisms, as well as the status after splenectomy. Certain manipulative procedures such as catheterization, intravenous cannulation, and surgery predispose as well, often to local infections.

Opportunistic microorganisms (which may be bacteria, fungi, parasites, or viruses) may cause infections exclusively in "compromised hosts" (for example, certain species of Bacillus), or may cause infections more frequently or more severely in compromised than in "normal" hosts (for example, Salmonella species). Their origins are either exogenous (from the living or inanimate environment) or endogenous (from the person's own flora in the intestinal tract, genital tract, or on the skin).

Some microbes are associated with specific defects. The localization of the infection is usually at the site of invasion, but spread and finally septicemia are particular dangers of

opportunistic infections. To take a few examples: Infections with Mycobacterium tuberculosis or with Staphylococcus aureus are observed in normal as well as in compromised hosts, but they are seen more frequently and tend to be more extensive in the latter group. Mycobacterium tuberculosis favors individuals with defective cell-mediated immunity (for example, those with Hodgkin's disease, malnutrition, or immunosuppression), as well individuals with diabetes mellitus and silicosis, with the majority of the infections localized in the lungs. Staphylococcus aureus favors persons with defects in the continuity of the skin (for example, with wounds or burns), with damaged lungs (for example, by cystic fibrosis or influenza), with defects in phagocytosis, and with diabetes mellitus. Among the viruses, the herpes simplex virus frequently affects individuals with T cell defects, as well as those with burns or atopic eczema. The resulting lesions are often more extensive than those observed in normal hosts. The fungus Candida albicans favors individuals with diabetes mellitus, hyperparathyroidism, and those under immunosuppression, on ovulation inhibitors, and on hyperalimentation, as well as drug addicts--septicemia being observed particularly in the last two groups. The parasite Pneumocystis carinii causes pneumonia in premature infants and immunosuppressed and hypogammaglobulinemic individuals.

Prognosis and therapy of opportunistic infections are complicated by the fact that successful antimicrobial chemotherapy is in part dependent on the body's defense mechanisms. Treatment of the underlying diseases therefore is of condition (for example, cytotoxic chemotherapy against tumors) may create a favorable environment for opportunistic infections.

Graevenitz, *Opportunistic Infection,* Encyclopedia of Science and Technology, Volume 12, 6th Edition.

APPENDIX K

Weiss, *AIDS: Balancing the Physician's Duty to Warn and Confidentiality Concerns*, 38 Emory L.J. 279, (1989)

Gavzy and Hetzel, *To Treat or Not to Treat: Healthcare Providers' Duties*, 126 N.J. Law. 52, (1989)

McDonald, *Ethical Problems for Physicians Raised by AIDS and HIV Infection: Conflicting Legal Obligations of Confidentiality and Disclosure*, 22 U.C. Davis L. Rev. 557 (1989)

Brandt, *Health Care Workers and AIDS*, 48 Md.L.Rev. 1 (1989)

Gostin, *Hospitals Health Care Professionals, and AIDS: The 'Right to Know' the Health Status of Professionals and Patients*, 48 Md.L.Rev. 12, (1989)

Herman and Gagliono, *AIDS, Therapeutic Confidentiality, and Warning Third Parties*, 48 Md.L.Rev. 55, (1989)

Fluss and Zeegers, *AIDS, HIV, and Health Care Workers: Some International Legislative Perspectives*, 48 Md.L.Rev. 77, (1989)

Rothenberg et.al., *The AIDS Project: Creating a Public Health Policy--Rights and Obligations of Health Care Workers*, 48 Md. L. Rev. 95, (1989)

Wade, *The Ohio Physician-Patient Privilege: Modified, Revised, and Defined*, 49 Ohio St.L.J. 1147, (1989)

Spece, *AIDS: Due Process, Equal Protection, and the Right to Treatment*, 4 Issues L. and Med. 283, (1988)

Talbot, *The Conflict Between a Doctor's Duty to Warn a Patient's Sexual Partner That the Patient has AIDS and a Doctor's Duty to Maintain Patient Confidentiality*, 45 Wash. and Lee L.Rev. 355, (1988)

Heath, *A Hospital's Dilemma: the Legal Implications of Promulgating Guidelines Concerning Human Immunodeficiency Virus*, 23 U.Rich.L.Rev. 39, (1988)

Banks, *AIDS and the Right to Health Care*, 4 Issues L. And Med. 151, (1988)

Harris, *AIDS and the Future*, 4 Issues L. And Med. 141, (1988)

Reiner, *AIDS Discrimination by Medical Care Providers: Is Washington Law an Adequate Remedy?*, 63 Wash.L.Rev. 701, (1988)

Spong, *AIDS and the Health Care Provider: Burgeoning Legal Issues*, 67 Mich.B.J. 610, (1988)

Albert, *A Right to Treatment for AIDS Patients?*, 92 Dick. L. Rev. 743, (1988)

Armstrong, *Confidentiality, Warning, and AIDS: A Proposal to Protect Patients, Third Parties, and Physicians*, 4 Touro L.Rev. 301, (1988)

Ensor, *Doctor-Patient Confidentiality Versus Duty to Warn in the Context of AIDS Patients and Their Partners*, 47 Md.L.Rev. 675 (1988)

Brennen, *Ensuring Adequate Health Care for the Sick: The Challenge of the Acquired Immunodeficiency Syndrome as an Occupational Disease*, 1988 Duke L.J. 29

Fahrner, *The Physician's Duty to Warn Non-Patients: AIDS enters The Equation* 5 Cooleg L.Rev. 353, (1988)

Geske, *Statutes Limiting Mental Health Professionals' Liability for the Violent Acts of Their Patients*, 64 Ind.L.J. 391, (1988-1989)

Shaffer, *Liability for Transmission of AIDS in the Hospital Workplace: A Critique of Mandatory AIDS Testing of Hospital Patients*, 90 W.Va.L.Rev. 652 (1987-1988)

Piorkowski, *Between a Rock and a Hard Place: AIDS and the Conflicting Physician's Duties of Preventing Disease Transmission and Safeguarding Confidentiality*, 76 Geo. L.J. 169, (1987)

Lavey, *Treating Patients With Communicable Diseases: Limiting Liability for Physicians and Safeguarding the Public Health*, 32 St.Louis.U.L.J. 75 (1987)

Burris, *Fear Itself: AIDS, Herpes and Public Health Decisions*, III Yale L.Pol'y Rev. 479, (1985)

Gellman, *Prescribing Privacy: The Uncertain Role of the Physician in the Protection of Patient Privacy*, 62 N.C.L.Rev. 255, (1984)

APPENDIX L

BIBLIOGRAPHY

1. Bedikian, *Riding on the Horns of a Dilemma: The Law of Contract v. Public Policy in the Enforcement of Labor Arbitral Awards,* 1988 Det. C.L. Rev. 693 (1988).

2. Berlowe, *Judicial Deference to Grievance Arbitration in the Private Sector: Saving Grace in the Search for a Well-Defined Public Policy Exception,* 42 U.Miami L.Rev. 767, January, (1988)

3. Block and Mittenthal, *Arbitration and the Absent Employee,* Proceedings of the 37th Annual Meeting of the National Academy of Arbitrators (1984), at pages 90-91.

4. Carey and Arthur, *The Developing Law on AIDS in the Workplace,* 46 Md. L. Rev. 284 (1987)

5. Edwards, *Judicial Review of Labor Arbitration Awards: The Clash Between the Public Policy Exception and the Duty to Bargain,* 64 Chi.-Kent L.Rev. 3, (1989)

6. Epidemic of Fear, A Guide to the Legal Problems of People With AIDS, Published by the LAMBDA Legal Defense Fund. (1990)

7. Friedman-Kien et al., *Disseminated Kaposi's Sarcoma in Homosexual Men,* Ann. Intern. Med., 96:693-700, 1982.

8. Gombar, *AIDS in the Workplace: Selected Legal Issues,* 350 Prac.L.Inst. 103, (1988).

9. Gostin, *The Politics of AIDS: Compulsory State Powers, Public Health, and Civil Liberties,* 49 Ohio St.L.J. 1017 (1989)

10. Graevenitz, *Opportunistic Infection,* Encyclopedia of Science and Technology, Volume 12, 6th Edition.Fallone, *Preserving the Public Health: a Proposal to Quarantine Recalcitrant AIDS Carriers,* 68 B.U.L.Rev. 441 (1988)

11. Gross and Greenfield, *Arbitral Value Judgements in Health and Safety Disputes, Management Rights Over Workers' Rights,* 34 Buffalo L.Rev. 645 (1985)

12. Harrington, *A Fatal Bias: AIDS and Minorities,* 14 Hum.Rts. 34 (1987) (Published by the Section of Individual Rights and Responsibilities, American Bar Association.)

13. Hauck, *AIDS and Arbitration, 1990 Lab. Law J. 293*

14. Heinsz, *Judicial Review of Labor Arbitration Awards: The Enterprise Wheel Goes Around and Around,* 52 Mo.L.Rev. 243, (1987)

BIBLIOGRAPHY

15. Helburn and Hill, *The Arbitration of Religious Practice Grievances*, 39 Arb.J. 3, (J 1984)

16. Hentoff, Note, *The Rehabilitation Act's Otherwise Qualified Requirement and the Aids Virus: Protecting the Public from Aids-Related Health and Safety Hazards*, 30 Ariz. L. Rev. 571, (1988)

17. Hill and Beck, *Some Thoughts on Just Cause and Group Discipline*, 41 Arb.J. 59, (J 1986)

18. Howlett, *The Arbitrator, the NLRB, and the Courts*, The Arbitrator, the NLRB, and the Courts, Proceedings of the 20th Annual Meeting, National Academy of Arbitrators, 67 (BNA Books, 1967)

19. Howlett, *Why Arbitrators Apply External Law, in LABOR ARBITRATION, A PRACTICAL GUIDE FOR ADVOCATES 257 (1990)*

20. Hoyman and Stallworth, *The Arbitration of Discrimination Grievances in the Aftermath of Gardner-Denver*, 39 Arb.J. 49, (S 1984)

21. Jason, McDougal, Dixon, Lawrence, Kennedy, Hilgartner, Aledort & Evatt, *HTLV-III/LAV Antibody and Immune Status of Household Contacts and Sexual Partners of Persons With Hemophilia*, 255 J. A.M.A. 212 (1986).

22. Joseph, Jr., *Criminal Procedure*, 48 La.L.Rev. 257 (1987)

23. Kendellen, *Aids: A Clinical Statement*, 126 N.J. Law. 14, (1989)

24. Koop, *The Surgeon General's Report on Acquired Immune Deficiency Syndrome*. (1987)

25. Leap, Srb and Petersen, *Health and Job Safety: An Analysis of Arbitration Decisions*, 41 Arb.J. (S 1986)

26. Macher, *Acquired Immune Deficiency Syndrome*, Encyclopedia of Science and Technology, Volume 1, 6th Edition.

27. Magee, *The Public Policy Exception to Judicial Deferral of Labor Arbitration Awards--How Far Should Expansion Go?*, 39 SCLR 465, (1988).

28. Margolis, *The AIDS Epidemic: Reality Versus Myth*, 72 Judicature 58, (1988).

29. Mendicino, *Characterization and Disease: Homosexuals and the Threat of Aids*, 66 N. C. L. Rev. 226, (1987).

BIBLIOGRAPHY

30. Merritt, *Communicable Disease and Constitutional Law: Controlling AIDS*, 61 N.Y.U.L. Rev. 739 (1986)

31. Mittenthal, *The Role of Law in Arbitration*, Developments in American and Foreign Arbitration, Proceedings of the 21st Annual Meeting, National Academy of Arbitrators, 42 (BNA Books, 1968).

32. Mittenthal, *Why Arbitrators Do Not Apply External Law, in LABOR ARBITRATION, A PRACTICAL GUIDE FOR ADVOCATES 287 (1990)*

33. Milhizer, *Legality of the 'Safe-Sex' Order to Soldiers Having AIDS*, (1988)

34. Milhizer, *AIDS Update*, 27-50-195 Army Law. 29, (1989)

35. Oldham, *Arbitration and Relentless Legalization in the Workplace*, in Arbitration 1990, New perspectives on Old Issues, Proceedings of the Forty-Third Annual Meeting, National Academy of Arbitrators, (Gruenberg, ed. 1990) (BNA)

36. Parmet, *AIDS and Quarantine: The Revival of an Archaic Doctrine*, 14 Hofstra L.Rev. 53 (1985)

37. Ray, *Protecting the parties' Bargain After Misco: Court Review of Labor Arbitration Awards*, 64 Ind.L.J. 1, (1988)

38. Record of 100th Congress, Second Session, Thursday June 9, 1988. 1988 WL 171107 (Cong.Rec.) 134 Cong.Rec. H4107-02.

39. Record of 101st Congress, First Session, Monday, October 2, 1989. 1989 WL 185305 (Cong.Rec.) 135 Cong.Rec. H6440-01.

40. Redfield, Markham, Salahuddin, Wright, Sarngadharan & Gallo, *Heterosexually Acquired HTLV-III/LAV Disease (AIDS-Related Complex and AIDS)*, 254 J. A.M.A. 2094 (1985).

41. Robinson, Jr., *AIDS and the Criminal Law: Traditional Approaches and a New Statutory Proposal*, 14 Hofstra L. Rev 91 (1985)

42. Schechter, *AIDS: How the Disease is Being Criminalized*, 3 Crim.Just. 6 (1988)

43. Schultz, AIDS: *Public Health and the Criminal Law*, VII St. Louis U.Pub.L.Rev. 65 (1988)

44. Scott and Taylor, *An Analysis of Absenteeism Cases Taken to Arbitration: 1975-1981*, 38 Arb.J. 61 (S 1983)

BIBLIOGRAPHY

45. Shelley, *Maternal Substance Abuse: The Next Step in the Protection of Fetal Rights?*, 92 Dick. L. Rev. 691, (1988)

46. Shulman, *AIDS Discrimination: Its Nature, Meaning and Function*, 12 Nova L.Rev. 1113, (1988)

47. Spaht, *Revision of the Law of Marriage: One Baby Step Forward*, 48 La.L.Rev. 1131, (1988)

48. St. Antoine, *Judicial Review of Labor Arbitration Awards: A Second Look at Enterprise Wheel and Its Progeny*, 75 Mich.L. Rev. 1137, 1160-61. (1977)

49. Stansbury, *Deadly and Dangerous Weapons and Aids: The Moore Analysis is Likely to be Dangerous*, 74 Iowa L. Rev. 951 (1989)

50. Stein, *AIDS in the Workplace: Opportunities for Cooperation*, in Proceedings of New York University, Forty Second Annual National Conference on Labor (B. Stein ed. 1989)

51. Stein, *Strategies for Dealing with AIDS Disputes in the Workplace*, 42 Arb.J. 21 (S 1987)

52. Washington, *Preventive Detention: Dangerous Until Proven Innocent*, 38 Cath.U.L.Rev. 271 (1988)

53. Wells-Petry, *Anatomy of an Aids Case: Deadly Disease as an Aspect of Deadly Crime*, 27-50-181 Army Law. 17, (1988)

54. Wilson, *Medical Evidence in Arbitration: Aspects and Dilemmas*, 39 Arb.J. 11 (S 1984)

55. Wolfson, *Arbitration and OSHA*, 38 Arb.J. 13 (S 1983)

56. Zack and Zack, *Arbitrators and Medical Evidence*, 39 Arb.J. 6 (S 1985)

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